

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10927 CERTIFICATE OF DEATH

10896
72

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE				
<i>Anne Arundel</i> MARYLAND		<i>Md</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY				
<i>Harmans</i>	<i>1 mo.</i>	<i>Md</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<i>Shipley Ave</i>	<i>Shipley Ave</i>					
3. NAME OF DECEASED (Type or print)	First	Middle	Last			
<i>Melitta</i>	<i>Grace</i>	<i>Applegaist</i>	<i>No. 6</i>			
4. DATE OF DEATH	Month	Day	Year			
<i>Nov. 6</i>			<i>1956</i>			
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.
<i>F</i>	<i>W.</i>	<i>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></i>	<i>10-13-19</i>	<i>37 yrs.</i>	Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?			
<i>clerk</i>	<i>Stiffey</i>	<i>Baltimore</i>	<i>White ave</i>			
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME					
<i>Henry J. Baumgartner</i>	<i>Annie C. Hartline</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	2701 Address			
<i>—</i>	<i>218-09-229</i>	<i>Kermit Baumgartner</i>	<i>White ave</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>PULMONARY EDEMA</i>				<i>11 HRS.</i>		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>CONGESTIVE HEART FAILURE</i>				<i>3 DAYS.</i>		
DUE TO (c) <i>METASTATIC CARCINOMA LEFT BREAST</i>				<i>9 MOS.</i>		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <i>11-5</i> , 19 <i>56</i> , to <i>11-7</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>11-7</i> , 19 <i>56</i> , and that death occurred at <i>12:21 A.M.</i> from the causes and on the date stated above.						
ADDRESS (Street, city or town, state) <i>M.D. 201 BTA BLVD, GLEN BURNIE, MD. 11-7-56.</i>						
DATE SIGNED						
ACTUAL SIGNATURE <i>Leon C. Perry</i>	M.D. <i>Leon C. Perry</i>					
PHYSICIAN'S NAME (Type) <i>Leon C. PERRY, MD</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11/9/56</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Emmanuel Cemetery</i>		22d. LOCATION (City, town, or county) <i>Baltimore</i> (State) <i>Md</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Paul A Neumann</i>	ADDRESS <i>6067 Half Rd</i>	24a. REC'D BY REGISTRAR <i>Clara Harlop</i>		24b. REGISTRAR'S SIGNATURE <i>Clara Harlop</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be signed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

WISCONSIN STATE BOARD OF HEALTH - BUREAU OF VITAL RECORDS

CERTIFICATE OF DEATH

NAME

ADDRESS

AGE

SEX

RACE

RELIGION

EDUCATION

EMPLOYMENT

DEATH DATE

CAUSE OF DEATH

DEATH PLACE

DEATH TIME

DEATH MONTH

DEATH YEAR

DEATH HOUR

DEATH MINUTE

DEATH SECOND

DEATH DAY

DEATH MONTH

DEATH YEAR

DEATH HOUR

DEATH MINUTE

DEATH SECOND

DEATH DAY

DEATH MONTH

DEATH YEAR

DEATH HOUR

DEATH MINUTE

DEATH SECOND

DEATH DAY

DEATH MONTH

DEATH YEAR

BUREAU V.

NOV 9 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10899 CERTIFICATE OF DEATH

Reg. Dist. No. 21

10897

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS 106 N. Linden Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First FRANK	Middle G	Last BALDWIN		
4. DATE OF DEATH	Month November	Day 12	Year 19 56		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 7, 1898		
9. AGE (In years last birthday) 58 yrs.	10. IF UNDER 1 YEAR Months 58	11. IF UNDER 24 HRS. Days 0	12. Hours 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor	10b. KIND OF BUSINESS OR INDUSTRY Farm Equipment Co	11. BIRTHPLACE (State or foreign country) Millersville, Maryland	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William E. Baldwin Sr.	14. MOTHER'S MAIDEN NAME Annastusia A. Deutsch				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 220-16-4735	17. INFORMANT Mrs Belle Baldwin- Wife- Same as # 2	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c) DUE TO DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Coronary Thrombosis & Block Atherosclerotic Heart Disease INTERVAL BETWEEN ONSET AND DEATH 20 days Unknown					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Annapolis	(County) M.D.	(State) Maryland
21. I certify that I attended the deceased from _____ alive on _____, and that death occurred at _____, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Edward S. Beck</i>	ADDRESS (Street, city or town, state) 41 Southgate Ave, Annapolis, Maryland			DATE SIGNED July 1959	
PHYSICIAN'S NAME (Type) Edward S. Beck	M D				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 15, 1956	22c. NAME OF CEMETERY OR CREMATORIUM St. Mary's Cemetery	22d. LOCATION (City, town, or county) Annapolis, Maryland	(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hopping Funeral Home</i>	ADDRESS ANNAPO利S, MARYLAND	24e. REC'D BY REGISTRAR 10 - J.P.	24f. REGISTRAR'S SIGNATURE		
VS A15 (4) 15M 9/55	DATE 10 - J.P.				

81-280M11AB—115E3X 90 793H11 050 3142 0MA 1124

BUREAU V. S.

NOV 16 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10898
28

Reg. Dist. No.

10928 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN lb 10mos. 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City		d. STREET ADDRESS 1600 N. Gilmore St.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Ethel	Middle	Last Barnes	4. DATE OF DEATH 11 12 19 56	Month	Day	Year
5. SEX Female		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/4/00	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR — — —	IF UNDER 24 HRS. — — —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY — — —		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME Alphonsus Curtis				14. MOTHER'S MAIDEN NAME Mary Curtis				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records		Address Crownsville State Hospital Crownsville, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 442 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Renal Failure DUE TO (c) Hypertensive Cardiovascular Disease								
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypostatic Pneumonia, Decubitus Ulcers								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 7/9 , 19 56 , to 11/12 , 19 56 , that I last saw the deceased alive on 7/9 , 19 56 , and that death occurred at 12:10 p.m. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Crownsville, Md.						
ACTUAL SIGNATURE <i>Lionel McHenry Mapp.</i>		DATE SIGNED 11/13/56						
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp.								
22a. BURIAL, CREMATION, REMOVAL (Specify) 11/10/56		22b. DATE THEREOF 11/10/56		22c. NAME OF CEMETERY OR CREMATORIY St. Peters Cemetery Baltimore		22d. LOCATION (City, town, or county) (State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE George G. Nelson		ADDRESS 1348 W. Calhoun St.		24a. REC'D BY REGISTRAR NOV 19 1956		24b. REGISTRAR'S SIGNATURE J. M. Joyce		

WISCONSIN STATE DEPARTMENT OF HEALTH - BIRKMORE - 18

CERTIFICATE OF DEATH

BUREAU V. S.
NOV 19 1956
RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 9,13,14 Film G206 11-14-56 et
CERTIFICATE OF DEATH

10899
22

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel		10929 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade		c. LENGTH OF STAY IN 1b 14 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Army Hospital		d. STREET ADDRESS 1609 E Forrest Avenue		d. DATE OF DEATH November 1 1956			
3. NAME OF DECEASED (Type or print) RICHARD		First HARRISON Middle BARNES Last		Month		Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 31 January 1917	9. AGE (In years lost birthday) 38 39rs.	IF UNDER 1 YEAR Months 38 Days 39		IF UNDER 24 HRS. Hours 39 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY U. S. Army		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME (Deceased) Charles H. Barnes				14. MOTHER'S MAIDEN NAME (Deceased) Dora Hedden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 15 Yrs		17. INFORMANT None		Address Wife, Mrs. Darie J. Barnes, 1609 E Forrest Avenue, Meade Heights, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute occlusion, right coronary artery DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH DOA			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>Israell S. Elliott</i> M.D. USAHM Ft. G. Meade, Maryland 1 Nov 56							
PHYSICIAN'S NAME (Type) ISRAEL S. ELLIOTT, LT COL, MC							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-5-56		22c. NAME OF CEMETERY OR CREMATORIAL Arlington National		22d. LOCATION (City, town, or county) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE John Cooke Inc.		ADDRESS 1217 St. Paul St. Baltimore, Maryland		24a. REC'D BY REGISTRAR DATE 1 Nov 56		24b. REGISTRAR'S SIGNATURE W.L. Saylor, 1ST LT, MSC	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU Y.

1956 8 NOV

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10900 CERTIFICATE OF DEATH

10900

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please reinforce carbon papers. Pages 2 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY <i>A.A.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>A.A.</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b <i>1b</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		d. STREET ADDRESS <i>1009 Poplar Ave.</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>U.S. A.G. General</i>				e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>FRANK</i>		First	Middle	Last	4. DATE OF DEATH <i>7-24-1956</i>	Month	Day	Year
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <i>7-24-1912</i>	9. AGE (In years last birthday) <i>44 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Wholesale Meat</i>		11. BIRTHPLACE (State or foreign country) <i>Williamsport Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>N. S.A.</i>		
13. FATHER'S NAME <i>Orville L. Beachley</i>		14. MOTHER'S MAIDEN NAME <i>Bessie Taylor</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>214-03-1178</i>		17. INFORMANT <i>Grace Smith Beachley</i>		Address <i>②</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Auto myocardial infarction</i> INTERVAL BETWEEN DUE TO <i>420.1</i> ONSET AND DEATH <i>20 min.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary artery disease</i> <i>5 yrs.</i> DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? IF EITHER, NOTIFY MEDICAL EXAMINER YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>20f. (City or town) 24</i>		(County)		(State)
21. I certify that I attended the deceased from <i>August</i> , 19 <i>56</i> , to <i>November 19<i>56</i></i> , that I last saw the deceased alive on <i>November 19<i>56</i></i> , and that death occurred at <i>9th A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>John H. Holzman</i> M.D. <i>90 Cathedral St.</i> DATE SIGNED <i>11/24/56</i> ADDRESS (Street, city or town, state) <i>Annapolis Md.</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Nov 27-56</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Hillcrest</i>		22d. LOCATION (City, town, or county) <i>Annapolis</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Taylor Sons</i>		ADDRESS <i>Annapolis Md.</i>		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE <i>J.W.T.S.</i>		

MANUFACTURED STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

DEATH CERTIFICATE

NAME OF DECEASED		NAME OF MARRIED NAME	
JAMES R. HARRIS		JAMES R. HARRIS	
ADDRESS		ADDRESS	
1012 42nd Street, Baltimore, Maryland		1012 42nd Street, Baltimore, Maryland	
CITY, STATE, ZIP CODE		CITY, STATE, ZIP CODE	
BALTIMORE, MD 21205		BALTIMORE, MD 21205	
SEX		SEX	
M		M	
AGE		AGE	
60		60	
RACE		RACE	
WHITE		WHITE	
RELIGION		RELIGION	
PROTESTANT		PROTESTANT	
EDUCATION		EDUCATION	
HIGH SCHOOL GRADUATE		HIGH SCHOOL GRADUATE	
OCCUPATION		OCCUPATION	
PAPERBOY		PAPERBOY	
EMPLOYER		EMPLOYER	
HARRIS PAPER COMPANY		HARRIS PAPER COMPANY	
MATERIAL PRESENT		MATERIAL PRESENT	
NO MATERIAL PRESENT		NO MATERIAL PRESENT	
TIME OF DEATH		TIME OF DEATH	
10:00 A.M.		10:00 A.M.	
DATE OF DEATH		DATE OF DEATH	
NOV 28 1956		NOV 28 1956	
CAUSE OF DEATH		CAUSE OF DEATH	
HEART DISEASE		HEART DISEASE	
MEDICAL RECORD NUMBER		MEDICAL RECORD NUMBER	
100-12345678		100-12345678	
SIGNATURE		SIGNATURE	
FBI - BALTIMORE		FBI - BALTIMORE	
RECEIVED		RECEIVED	
NOV 28 1956		NOV 28 1956	

RECEIVED

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10903

10930 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>AA Co</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ridge</i>	c. LENGTH OF STAY IN 1b <i>11</i>	b. COUNTY <i>AA Co</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Md ave Blvd Park Pasadena</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural False Stone AA Co</i>	
d. STREET ADDRESS <i>Md ave Blvd Park Pasadena</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Walter Thomas Beall</i>	First	Middle	Last
4. DATE OF DEATH <i>Nov 27 - 1956</i>	Month	Day	Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 25-1896</i>
9. AGE (In years lost birthday) <i>62 yrs.</i>	10. IF UNDER 1 YEAR <i>Months</i>	11. IF UNDER 24 HRS. <i>Days Hours Min.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Montgomery Co</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Jesse Beall</i>	14. MOTHER'S MARRIED NAME <i>Maryann Robinson</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>217-14-2740</i>	17. INFORMANT <i>mrs Emma Beall</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the rectum</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>none</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Pasadena, Md.</i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>November 13, 1956</i> , to <i>November 27, 1956</i> , that I last saw the deceased alive on <i>November 26, 1956</i> , and that death occurred at <i>9:15 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Pasadena, Md.</i> DATE SIGNED <i>Nov 27, 1956.</i>			
ACTUAL SIGNATURE <i>R.M. McLaughlin</i>	M.D.		
PHYSICIAN'S NAME (Type) <i>R.M. McLaughlin</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Nov 30-56</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Western Cemetery</i>	22d. LOCATION (City, town, or county) <i>Baltimore Md</i> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard G Trindell Ellyn Barnes Md</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE <i>11-28-56</i>	24b. REGISTRAR'S SIGNATURE <i>L. J. G. 11-28-56</i>

DEATH CERTIFICATE

BUREAU V. S.

NOV 29 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10931 CERTIFICATE OF DEATH

Reg. Dist. No. 10904

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 1yr. 9mos. 29days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dayton					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS None given		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First John	Middle	Last Bell	4. DATE OF DEATH 11	Month 11	Day 16	Year 19 56		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Not given	9. AGE (In years last birthday) 81? yrs.	IF UNDER 1 YEAR Months -	IF UNDER 24 HRS. Days -	Hours -	Min. -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Work		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME West Bell		14. MOTHER'S MAIDEN NAME Mary Liza Bell							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records		Address Crownsville State Hospital Crownsville Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia <i>600.0</i>		INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Old Age									
DUE TO (c)									
DUE TO (b)									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pyelitis, dehydration and malnutrition		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Crownsville, Md.		(County) Crownsville, Md.	(State) Md.
21. I certify that I attended the deceased from 11/1 , 19 56 , to 11/16 , 19 56 , that I last saw the deceased alive on 11/15 , 19 56 , and that death occurred at 10:00 a.m. , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Lionel McHenry Mapp.</i>		ADDRESS (Street, city or town, state) Crownsville, Md.							DATE SIGNED 11/16/56
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp.									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-19-1956		22c. NAME OF CEMETERY OR CREMATORIUM Hopkins Chapel		22d. LOCATION (City, town, or county) HIGHLAND MD.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>F.C. Beglebottom Elliott City</i>		ADDRESS <i>Elliott City</i>		24a. REC'D BY REGISTRAR <i>Katherine Joyce</i>		24b. REGISTRAR'S SIGNATURE <i>Katherine Joyce</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK - DEPARTMENT OF MOTOR VEHICLES
SPECIAL STATE LICENSE - CERTIFICATE OF DEATH

REAU V. S.

OY 21 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10932 CERTIFICATE OF DEATH

Reg. Dist. No.

210905

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn		c. LENGTH OF STAY IN 1b 20 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Old Quarterfield Rd. Box 454		d. STREET ADDRESS Same		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Anna Blaudow		First	Middle	Last	4. DATE OF DEATH November 6th,	Month	Day	Year 19 56
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 3/2/88	9. AGE (in years lost birthday) 68 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) East Prussia, Germany.		12. CITIZEN OF WHAT COUNTRY? Germany		
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. William Blaudow (husband)		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis, primary source left breast INTERVAL BETWEEN ONSET AND DEATH 6 years DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Mental troubles 15 years DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Glen Burnie	(County) Md.	(State) Md.
21. I certify that I attended the deceased from 10/28/56 , 19_____, to 11/6/56 , 19_____, that I last saw the deceased alive on 11/5/56 , 19_____, and that death occurred at 12:20 A.M. From the causes and on the date stated above. ACTUAL SIGNATURE Gustave H. Faubert, M.D. ADDRESS (Street, city or town, state) Glen Burnie, Md. DATE SIGNED 11/6/56								
PHYSICIAN'S NAME (Type) Gustave H. Faubert, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 8-56		22c. NAME OF CEMETERY OR CREMATORIUM Holy Cross Brooklyn, N.Y.		22d. LOCATION (City, town, or county) Glen Burnie, Md. (State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Donald G. Fink		ADDRESS Glen Burnie, Md.		24a. REC'D BY REGISTRAR Nov 8-56		24b. REGISTRAR'S SIGNATURE L. J. Deeba		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEATH CERTIFICATE

NO. 44

DECEASED

1956

NAME

MATERIAL

GENDER

NAME

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10906

Reg. Dist. No. 24

10933 CERTIFICATE OF DEATH

1. PLACE OF DEATH D. COUNTY AA		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) D. STATE Md.		b. COUNTY M	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sunset Beach		c. LENGTH OF STAY IN lb Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sunset Beach			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sunset Beach				d. STREET ADDRESS Sunset Beach		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Neva	Middle Amanda	Last Bradshaw	4. DATE OF DEATH	Month 11	Day 18	Year 19 56
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 2/11/83	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Benton		14. MOTHER'S MAIDEN NAME Josephine Evans					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Family		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE 5 YEARS (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Riviera Beach Md.	(County) Riviera Beach Md.	(State) Md.
21. I certify that I attended the deceased from MARCH , 19 52 , to Nov. 18 , 19 56 , that I last saw the deceased alive on Nov. 16 , 19 56 , and that death occurred at 8:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Riviera Beach Md. DATE SIGNED 11/4/56							
ACTUAL SIGNATURE <i>J. Brady Smith</i>	M.D.						
PHYSICIAN'S NAME (Type) <i>J. BRADY SMITH</i>	RIVIERA BEACH, MD.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/21/56	22c. NAME OF CEMETERY OR CREMATORIAL Western Cemetery			22d. LOCATION (City, town, or county) Baltimore, Md. (State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes --- 130 E. Fort Ave.				ADDRESS	24a. REC'D BY REGISTRAR DATE 11-22-56	24b. REGISTRAR'S SIGNATURE Louis J. DeAlba	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

WILSON COUNTY DEPARTMENT OF HEALTH - GALTWOOD, NC

DEATH CERTIFICATE

SEARCHED

INDEXED

SERIALIZED

FILED

BUREAU # 4

BUREAU # 4

RECEIVED
MAY 3 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10907

10934 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY A.A. County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X North Linthicum		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		d. STREET ADDRESS 4409 Leeds Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ellanora Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ANNA VIRGINIA BRADY		First	Middle	4. DATE OF DEATH NOVEMBER 4 - TH	Month	Day	Year 19 56
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1890	9. AGE (In years lost birthday) 66 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Howard E.R. Hunter		14. MOTHER'S MAIDEN NAME Sophia E. Wilkerson		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO.		17. INFORMANT Harvey Brady Sr. 4409 Leeds Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 153X		<i>Stenosis of rectum</i>		INTERVAL BETWEEN ONSET AND DEATH 2 days			
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b)		<i>Recurrent carcinoma of rectum</i>		3 mos.			
(c)		<i>Carcinoma of rectal sigmoid</i>		1-3 mos.			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from March , 19 56 , to November 4 , 19 56 , that I last saw the deceased alive on November 4 , 19 56 , and that death occurred at 8 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Simon Brager				ADDRESS (Street, city or town, state) 1800 North Charles Street		DATE SIGNED	
PHYSICIAN'S NAME (Type) Simon Brager, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 7-1956		22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery		22d. LOCATION (City, town, or county) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. L. Gilbert		ADDRESS 1300 Eutaw Place		24a. REC'D BY REGISTRAR Nov 7 1956		24b. REGISTRAR'S SIGNATURE J. V. Hendrich	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REGISTRATION CERTIFICATE OF DEATH

BUREAU V. S.
RECEIVED
NOV 7 1956

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10908

10901 CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH

COUNTY	Anne Arundel	MARYLAND
CITY (If outside corporate limits, write RURAL or and give nearest town)	RURAL	
TOWN	Annapolis	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	66 College Creek Terrace	

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE	Maryland	COUNTY	Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town)	RURAL		
TOWN	Annapolis		
STREET ADDRESS	66 College Creek Terrace		

3. NAME OF DECEASED

(First)	(Middle)	(Last)
Joseph H. Brandford		

4. DATE OF DEATH

(Month)	(Day)	(Year)
11	9	1956

5. SEX

Male

6. COLOR OR RACE

Col.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

Married

8. DATE OF BIRTH

9-3-1892

9. AGE last birthday

64 yrs.

IF UNDER 1 YEAR	IF UNDER 24 HRS.
Months	Days

Hours	Min.
-------	------

10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Cook (retired)

10b. KIND OF BUSINESS OR INDUSTRY

25 Naval Rd.

11. BIRTHPLACE (State or foreign country)

Chesterfield, Md

12. CITIZEN OF WHAT COUNTRY?

26 Sa

13. FATHER'S NAME

John Brandford

14. MOTHER'S MAIDEN NAME

Mary Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, No, or unknown) (If Yes, give war or dates of service)

Yes W. W. I

16. SOCIAL SECURITY NO.

219-16-1131

17. INFORMANT & ADDRESS

Agnes Brandford, Annapolis, Md

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH**420.1 IMMEDIATE CAUSE**

(A)

ANTECEDENT CAUSE(S)

DUE TO

DISEASES OR CONDITIONS, IF ANY,

(B)

GIVING RISE TO THE ABOVE CAUSE

STATING UNDERLYING CAUSE LAST.

DUE TO

(C)

18. MEDICAL CERTIFICATION

Acute Coronary Thrombosis	INTERVAL BETWEEN ONSET AND DEATH 15 minutes
---------------------------	--

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

Generalized Atherosclerosis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?YES NO **21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)****21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)**

M.

21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

M.D.

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

M.

21e. INJURY OCCURRED While Not while at work at work
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ... to ... , that I last saw the deceased alive on ..., and that death occurred at ... , from the causes and on the date stated above.

SIGNATURE

R. J. Richardson

ADDRESS (Street, city, town, state)

DATE SIGNED
11/10/56**23. BURIAL, CREMATION, REMOVAL (SPECIFY)**

Burial

DATE THEREOF

11-14-56

NAME OF CEMETERY OR CREMATORIUM

Annapolis National Cemetery

LOCATION (City, town, or county) (State)

Annapolis, Md

24. REC'D BY REGISTRAR

Nov. 14, 1956

REGISTRAR'S SIGNATURE

Wm. J. Leach

25. FUNERAL DIRECTOR'S SIGNATURE

William Reese, Jr.

ADDRESS

Annapolis, Md

DATE

AT BROWNSVILLE - TEXAS TO MEMPHIS STATE MAIL

PAGE 40 STAMPED 1956

ONE ADDITIONAL DOLLAR IS CHARGED FOR

POSTAGE AND HANDLING

BUREAU U.S.

NOV 13 1956

REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10902 CERTIFICATE OF DEATH

10909
21

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>A. A.</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b <i>RURAL</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		d. STREET ADDRESS <i>27 College Cr Tr</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>27 College Cr Tr.</i>				d. STREET ADDRESS <i>27 College Cr Tr</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Mary E. Hunt</i>		First	Middle	Last	4. DATE OF DEATH <i>Butler Nov 20 1956</i>	Month	Day	Year
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>12-25-1897</i>		9. AGE (In years last birthday) <i>58 yrs.</i>	IP UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Brown's Woods, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>John E. Hunt</i>		14. MOTHER'S MAIDEN NAME <i>Harriett Hunt</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Hollis Butler - Q.T.C. Ch. Terence Murphy</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		<i>Arteriosclerotic Heart Disease</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>		
420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)						
DUE TO								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Skidmore</i>		(County) <i>Elkridge</i> (State) <i>Md.</i>
19								
21. I certify that I attended the deceased from <i>Jan 21</i> , 19 <i>56</i> , to <i>Nov 20</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Nov 3rd</i> , 19 <i>56</i> , and that death occurred at <i>12:30 AM</i> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>62 Cathedral St</i>		DATE SIGNED <i>11-23-56</i>
ACTUAL SIGNATURE <i>Fayre W. Allen</i>								
PHYSICIAN'S NAME (Type) <i>Fayre W. Allen</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-24-56</i>		22c. NAME OF CEMETERY, OR CREMATORIAL <i>Broad Neck</i>		22d. LOCATION (City, town, or county) <i>Elkridge, Md.</i>		(State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, Jr. Annapolis, Md.</i>		ADDRESS <i>18</i>		24a. REC'D BY REGISTRAR <i>Nov 27 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Tom J. French</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11703 CERTIFICATE OF DEATH

BUREAU V. S.

NOV 27 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10903 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10901

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files. **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial; cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>A.A.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	c. LENGTH OF STAY IN 1b	b. COUNTY <i>A.A.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <i>Williams Dr.</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <i>PATRICIA</i>	Middle <i>L.</i>	Last <i>CAPLE</i>		
4. DATE OF DEATH	Month <i>11</i>	Day <i>15</i>	Year <i>1956</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>11-20-1954</i>		
9. AGE (In years last birthday) 1 yrs.	10. IF UNDER 1YEAR Months <i>11</i>	11. IF UNDER 24 HRS. Days <i>4</i>	12. IF UNDER 24 HRS. Hours <i>5</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	11. BIRTHPLACE (State or foreign country) <i>California</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Edward S. Caple</i>	14. MOTHER'S MAIDEN NAME <i>Jane Louise Herrick</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —	16. SOCIAL SECURITY NO. —	17. INFORMANT <i>EDWARD S. CAPLE #2</i>	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>929.8</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
			INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fell down bank into water</i>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>11</i> p. m. <i>1956</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) <i>Arlington</i>	(County) <i>A.A. Co</i>	(State) <i>MD</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>J. Shultz</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <i>11/15/56</i>	
EXAMINER'S NAME (Type) <i>E.L. Wharst</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>11/20/56</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington Nat'l</i>	22d. LOCATION (City, town, or county) <i>Arlington</i>	(State) <i>VA.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Foy & Sons</i>	ADDRESS <i>Annapolis, Md.</i>	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE <i>D. Orme</i>		

FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

OCT 21 1956

RECEIVED

1
 10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your information.
 Letter from F.O.D. or removal.

Item 20b Film 208 12-28-56 ¹⁹⁵⁶

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10910

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>a a Co</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>a a</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lothian</i>	c. LENGTH OF STAY IN 1b <i>60</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lothian</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <i>Otis</i>		4. DATE OF DEATH <i>Chapman</i>	Month <i>11</i> - Day <i>28</i> - Year <i>1956</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept-13-1912</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Get Policeman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Policeman</i>	10c. BIRTHPLACE (State or foreign country) <i>Pace Fla</i>		
13. FATHER'S NAME <i>Otis Chapman</i>		14. MOTHER'S MAIDEN NAME <i>Mae Wyche</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> YES, no, or unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>- - -</i>	17. INFORMANT <i>Mrs Elise Chapman</i> Address <i>2</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Crushing Injury & Chest</i> <i>822X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Fracture of Skull</i> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Tractor turned over on subject</i>					
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Holiday</i>	20f. (City or town) <i>Baltimore</i>	(County) <i>B.B.</i>	(State) <i>Md.</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Linhardt</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>11/29/56</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12-1-56</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington National Cemetery Memorial</i>	22d. LOCATION (City, State, Va., etc.) <i>Hyattsville Md</i>	(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hysongs Funeral Home Wal-Mart K.C.</i>		ADDRESS	24a. REC'D BY REGIS RA <i>U.S. Marshals</i>	24b. REGISTRAR'S SIGNATURE <i>U.S. Marshals</i>	

BUREAU V.

W 30 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10911

10904 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 21

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the remains prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)							
<i>Anne Arundel</i>		a. STATE	<i>Maryland Anne Arundel</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	<i>Annapolis</i>						
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
<i>10 00</i>		<i>RFD Box 37 Millersville, Md.</i>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS							
<i>Weems Crk.</i>		<i>11 15 1956</i>							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First	Middle						
<i>else belli</i>		<i>Chatman</i>							
4. DATE OF DEATH		Month	Day						
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours	Min.
<i>Female Colored</i>		<i>1 - 31 / 1935</i>	<i>21</i>	<i>11</i>	<i>15</i>	<i>1956</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
<i>Domestic</i>				<i>Waterbury, Md</i>		<i>U.S.A.</i>			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
<i>David Ross</i>		<i>Genevieve Brown</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
<i>No</i>		<i>218-32-5877</i>		<i>Genevieve Gross - Gladyside, Md</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>929.8</i> DUE TO <i>Browning</i> INTERVAL BETWEEN ONSET AND DEATH									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Sudden</i>									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>attempted to rescue child in water</i>									
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year <i>11/11 1956</i>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Wrens Creek</i>	20f. (City or town) <i>Hager</i>	(County) <i>Hager</i>	(State) <i>MD</i>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>John L. Linkhardt</i>		DATE SIGNED <i>11/11/56</i>							
EXAMINER'S NAME (Type) <i>E. Linkhardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-19-56</i>		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Our Lady of the Field Cemetery, Annapolis, Md.</i>		22d. LOCATION (City, town, or county) <i>Millersville, Md.</i>		(State) <i>MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, Jr. Annapolis, Md.</i>		ADDRESS <i>William Reese, Jr. Annapolis, Md.</i>		24a. REG'D BY REGISTRAR <i>Nov. 20, 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Wm. J. Trends</i>			

REAU V. S.

OY 21 1956

DECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10902

10905 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Homewood Conv'l. Home		d. STREET ADDRESS 59 Amos Garrett Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First DANIEL	Middle H	Last DAVIS	4. DATE OF DEATH NOVEMBER 18	Month Day Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 25, 1884	9. AGE (In years lost birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motorman		10b. KIND OF BUSINESS OR INDUSTRY Elect. R.R.		11. BIRTHPLACE (State or foreign country) Riva, Maryland	
13. FATHER'S NAME Daniel K. David		14. MOTHER'S MAIDEN NAME Mildred Redmond		12. CITIZEN OF WHAT COUNTRY USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	No	16. SOCIAL SECURITY NO. 219-16-2440	17. INFORMANT Mr. Channing H. Davis, Son - same as # 2	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Pulmonary DUE TO (c) Arteriosclerotic Heart Disease					
INTERVAL BETWEEN ONSET AND DEATH 1 month					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from APRIL 1956 , to 18 NOV 1956 , that I last saw the deceased alive on 18 Nov 1956 , and that death occurred at 10:55 AM , from the causes and on the date stated above.					
ADDRESS (Street, city or town, state)					
ACTUAL SIGNATURE Edward S. Beck M.D.					
DATE SIGNED 11/19/56					
PHYSICIAN'S NAME (Type) Edward S. Beck MD 41 Southgate Ave. Annapolis, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-20-56	22c. NAME OF CEMETERY OR CREMATORIUM St. Anne's Cemetery	22d. LOCATION (City, town, or county) (State) Annapolis, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME ANNAPOLIS, MD.					
ADDRESS					
24a. REC'D BY REGISTRAR DATE					
24b. REGISTRAR'S SIGNATURE John Smith					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be delivered to the funeral director, Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MANUFACTURE STATE DEPARTMENT OF HEALTH - CALIFORNIA

CERTIFICATE OF DEATH

OY 21 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10906 CERTIFICATE OF DEATH

10912
(10912)

Reg. Dist. No.

51

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY CALVERT		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. LENGTH OF STAY IN 1b 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Susby		d. STREET ADDRESS 04X-2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR, INSTITUTION ANNE ARUNDEL GEN. HOSP.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First VIRGIL	Middle 	Last DAWKINS	4. DATE OF DEATH NOV. 8 1956	Month NOV.	Day 8	Year 1956	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 10, 1910	9. AGE (In years lost, birthday) yrs. 46	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William Dawkins		14. MOTHER'S MAIDEN NAME Mary Ann Johnson				Address 1733 Ashland Ave		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-01-380		17. INFORMANT Resetta Dawkins		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED PERITONITIS DUE TO 540.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) and PANCREATITIS, ACUTE PERFORATED GASTRIC ULCER,		
						INTERVAL BETWEEN ONSET AND DEATH 11 days		
20a. MEDICAL CERTIFICATION 260x		20b. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DIABETES MELLITUS				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day 19	20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 98 Cathedral St.	(County) Calvert	(State) Md.
21. I certify that I attended the deceased from 11-1-1956 to 11-8-1956 that I last saw the deceased alive on 11-8-1956 , and that death occurred at 3:10 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Jesse L. Wilkins M.D. ADDRESS (Street, city or town, state) 98 Cathedral St. Annapolis, Maryland DATE SIGNED 11-8-56								
22a. BURIAL/CREMATION, REMOVAL (Specify) 11-11-56		22b. DATE THEREOF St. John's		22c. NAME OF CEMETERY OR CREMATORIUM St. John's		22d. LOCATION (City, town, or county) Calvert		
23. FUNERAL DIRECTOR'S SIGNATURE P.E. Sewell		ADDRESS Prince Frederick		24a. REC'D BY REGISTRAR DATE 11/11/56		24b. REGISTRAR'S SIGNATURE H. W. Ward		

81. ЗРОВІТЬСЯ НАДІЯНЮ ТИМ, КОДОВЕ СЛАУЖИТЬ

BUREAU V.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 155 10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10913

10903 CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS	Anne Arundel Annapolis, Md. 7th. District Rescue Squad Ambulance	MARYLAND LENGTH OF STAY (In this place) Minutes	STATE CITY (If outside corporate limits, write RURAL and give nearest town) Maryland TOWN STREET ADDRESS (If rural give location)
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
Baby Boy		Dean	Nov. 20 1956
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 20 November 1956
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday yrs. Months Days Hours Min.
13. FATHER'S NAME Edward Thomas Dean		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None	17. INFORMANT & ADDRESS Betty McCuen Dean
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) Initial respiratory failure 162.5 ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) Prematurity GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) 21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 20 Nov. 1956, to 20 Nov. 1956, that I last saw the deceased alive on 20 Nov. 1956, and that death occurred at 9:30 p.m. from the causes and on the date stated above. SIGNATURE <i>F.H. Hendrick</i> M.D. Shady Side, Md. ADDRESS (Street, city, town, state) DATE SIGNED 21 Nov. 56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 1956	NAME OF CEMETERY OR CREMATORIAL PRIVATE
24. REC'D BY REGISTRAR DATE 10 - 0.00		REGISTRAR'S SIGNATURE John M. Gandy & Sons	LOCATION (City, town, or county) Annapolis Neck, Md. ADDRESS Annapolis, Md.
25. FUNERAL DIRECTOR'S SIGNATURE John M. Gandy & Sons Annapolis, Md.			

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DEPARTMENT OF STATE - CHAMBERS

10001

STATE OF SOUTH DAKOTA

REGISTRATION NUMBER 10001

REGISTRATION DATE 10/1/56

EXPIRATION DATE 10/1/57

LOCATION 10001

OWNER'S NAME JAMES MCGEE

VEHICLE DESCRIPTION 1956 FORD

STATE 10001

MANUFACTURER'S NAME FORD

VEHICLE NUMBER 10001

YEAR 1956

TYPE PASSENGER CARS

CLASS 10001

STATE 10001

MANUFACTURER'S NAME FORD

VEHICLE NUMBER 10001

YEAR 1956

TYPE PASSENGER CARS

CLASS 10001

STATE 10001

MANUFACTURER'S NAME FORD

VEHICLE NUMBER 10001

YEAR 1956

TYPE PASSENGER CARS

CLASS 10001

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MANUFACTURER'S NAME FORD

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YEAR 1956

TYPE PASSENGER CARS

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YEAR 1956

TYPE PASSENGER CARS

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YEAR 1956

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CLASS 10001

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MANUFACTURER'S NAME FORD

VEHICLE NUMBER 10001

YEAR 1956

TYPE PASSENGER CARS

CLASS 10001

STATE 10001

MANUFACTURER'S NAME FORD

VEHICLE NUMBER 10001

YEAR 1956

TYPE PASSENGER CARS

CLASS 10001

STATE 10001

BUREAU V. 8

NOV 26 1956

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 155-10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10914

1099 CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN		Anne Arundel MARYLAND Annapolis		STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		Maryland Anne Arundel Annapolis	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		916 Spa Road		STREET ADDRESS		(If rural give location) 916 Spa Road	
3. NAME OF DECEASED (First) MARTHA (Middle) ENNIS (Type or Print)				4. DATE OF DEATH November 25, 1950			
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH May 10, 1898	9. AGE last birthday 58 yrs.	10. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Davidsonville, Maryland	12. CITIZEN OF WHAT COUNTRY?
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				13. FATHER'S NAME James Edward Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. None			
17. INFORMANT & ADDRESS Sylvia Ennis 916 Spa Rd. Annapolis, Md.				14. MOTHER'S MAIDEN NAME Caroline Pratt			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 170x IMMEDIATE CAUSE (A) <i>Metastatic Carcinoma</i> ANTECEDENT CAUSE(S) DUE TO <i>Coronary / Breast</i> DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <i>Coronary</i> (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19e. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from 11-16-56 , 1956 , to 11-16-56 , 1956 , that I last saw the deceased alive on 11-15-56 , 1956 , and that death occurred at 55 M, from the causes and on the date stated above. SIGNATURE <i>J. Allen</i> ADDRESS (Street, city, town, state) <i>62 Cathedral</i> DATE SIGNED <i>11-26-56</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Nov. 28, 1956		NAME OF CEMETERY OR CREMATORIUM Brewer Hill Cemetery		LOCATION (City, town, or county) West St. Annapolis, Md. (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>J. J. French</i>		25. FUNERAL DIRECTOR'S SIGNATURE Sylvia Hicks Hyman, 43-45 Northwest St.		ADDRESS	
DATE 10-10-1956							

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NOV 28 1956

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NOV 28 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10909 CERTIFICATE OF DEATH

10915

Reg. Dist. No.

21

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Truxton Hgts.		d. STREET ADDRESS Truxton Hgts	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JUAN Middle ESPIRITU		4. DATE OF DEATH Month NOVEMBER Day 11 Year 19 56	
5. SEX Male Philippine		6. COLOR OR RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Feb. 11, 1911 9. AGE (In years lost birthday) 45 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Private Yacht 11. BIRTHPLACE (State or foreign country) Philippine Islands	
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-184919 17. INFORMANT Mrs Anna E. Espiritu- Wife- Same as # 2 Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 527.2 DUE TO Acute pulmonary edema INTERVAL BETWEEN ONSET AND DEATH 3+ hrs		INTERVAL BETWEEN ONSET AND DEATH 61 mon	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) P DUE TO (D.O.A.)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 3A M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Frank M. Shipley</i> M.D. ADDRESS (Street, city or town, state) 63 College Ave. Annapolis, Md. DATE SIGNED 11/15/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 13, 1956	
22c. NAME OF CEMETERY OR CREMATORIUM St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hopping Funeral Home</i>		ADDRESS Annapolis, Md.	
24a. REC'D BY REGISTRAR <i>J. O. Smith</i>		24b. REGISTRAR'S SIGNATURE <i>J. O. Smith</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

CERTIFICATE OF DEATH

SEARCHED	INDEXED	SERIALIZED	FILED
NOV 14 1956			
FBI - BALTIMORE			
BUREAU V. 8			
NOV 14 1956			
FBI - BALTIMORE			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after this copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 7 Film G207 11-26-56 et

10916

10936 CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	ANNE ARUNDEL GLEN BURME	MARYLAND LENGTH OF STAY (In this place)	STATE Maryland COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore STREET ADDRESS (If rural give location) 509 Robert St.
HOSPITAL OR INSTITUTION OR STREET ADDRESS	PLAZA MANOR CONV. HOME		
3. NAME OF DECEASED (First) FRAINK W. (Middle) W. (Last) FISHER (Type or Print)		4. DATE (Month) Nov (Day) 14 (Year) 1956 OF DEATH	
5. SEX M	6. COLOR OR RACE C	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffuer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Moses Fisher		14. MOTHER'S MAIDEN NAME Ella Montague	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS Mrs. Obelia Smith Rosedale St. 1913	
18. MEDICAL CERTIFICATION METASTASES' GENERALIZED OF CARCINOMA OF The LARYNX			
INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 161X IMMEDIATE CAUSE (A) _____ ANTECEDENT CAUSE(S) DUE TO _____ DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE DUE TO _____ STATING UNDERLYING CAUSE LAST. (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? May 56 to Nov 14 1956			
22. I hereby certify that I attended the deceased from May 56 to Nov 14 1956 , that I last saw the deceased alive on Nov 1 1956 , and that death occurred at 8:30 P.M. from the causes and on the date stated above. SIGNATURE <i>Joseph T. Fisher</i> ADDRESS (Street, city, town, state) 103 BALTO. ANNAP. BLVD. N.C. Bldg. 6 DATE SIGNED 11/11/1956			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 11-17-56 NAME OF CEMETERY OR CREMATORIAL Mt. Auburn Cem LOCATION (City, town, or county) Baltimore, Md. (State) Md.	
24. REC'D BY REGISTRAR DATE NOV 20 1956		REGISTRAR'S SIGNATURE <i>L. J. DeAlba</i> 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 578 W. J. Deader / Biddlecut	

STATE OF CALIFORNIA
DEPARTMENT OF MOTOR VEHICLES

CERTIFICATE OF DEATH

NOV 20 1956

SEARCHED INDEXED SERIALIZED FILED NOV 20 1956

SEARCHED INDEXED

SERIALIZED FILED

REAU V. S.

NOV 20 1956

RECEIVED
DEPARTMENT OF MOTOR VEHICLES

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10917

10937 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH

COUNTY

CITY (If outside corporate limits, write RURAL
OR and give nearest town)

TOWN

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

MARYLAND

LENGTH OF STAY
(in this place)

14 mo

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)

OR
TOWNSTREET
ADDRESS

(If rural give location)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10910 CERTIFICATE OF DEATH

10918

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Anne Arundel</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		d. STREET ADDRESS <i>713 Warren Drive</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Anne Arundel General Hosp.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Mary Elizabeth Fulton</i>		First	Middle	Last	4. DATE OF DEATH <i>May 24, 1867</i>	Month <i>May</i>	Day <i>24</i>	Year <i>1956</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 24, 1867</i>		9. AGE (In years l/m/b/d) yrs. <i>87</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Jeremiah Hall</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Masterson</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>George Fulton #2</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>5 years</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>cataract both eyes, tumor in abdomen</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>-</i>						
20c. TIME OF INJURY Hour p. m.	Month 19	Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>-</i>	20f. (City or town) <i>-</i>	(County)	(State)	
21. I certify that I attended the deceased from <i>Oct.</i> , 1950, to <i>Nov. 8th</i> , 1956, that I last saw the deceased alive on <i>Nov. 8th</i> , 1956, and that death occurred at <i>1537 M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>-</i> DATE SIGNED <i>Elizabeth Rodler M.D.</i>								
ACTUAL SIGNATURE <i>Elizabeth Rodler</i>	PHYSICIAN'S NAME (Type) <i>EDITH RODLER M.D.</i>	M.D.	<i>45 Franklin St. Annapolis</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11-12-1956</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Evergreen Cemetery</i>	22d. LOCATION (City, town, or county) <i>New Brunswick N.J.</i>	(State)				
22e. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Taylor & Sons Annapolis, Md.</i>	ADDRESS <i>-</i>	24a. REC'D BY REGISTRAR <i>J.W. - J. Draneck</i>	24b. REGISTRAR'S SIGNATURE <i>-</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF WASHINGTON
DEPARTMENT OF DEATH

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BUREAU V. S.

NOV 13 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10938 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10919
Reg. Dist. No. 20

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Beverly Beach) Mayo		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mayo	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS Beverly Beach	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Dr. Vincent Gould		First	Middle	Last	4. DATE OF DEATH Month November 7 Day Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH January 15, 1900	9. AGE (in years at birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY General practice		11. BIRTHPLACE (State or foreign country) Canada	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Edith MacLeod		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Helen H. Gould-Wife Address Arundel Apts. Apt 12 A.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cardiac Disease 4343 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), storing the underlying cause lost. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Natural causes					
20c. TIME OF INJURY Month, Day, Year Hour 7:30 p.m. 11-7-56 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Mayo, Anne Arundel, Maryland	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Elmer G. Linhardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED November 9, 1956	
EXAMINER'S NAME (Type) Elmer G. Linhardt M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Nov. 12, 56		22c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Crematory	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hopping Funeral Home</i>		ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR NOV 13 1956	
				24b. REGISTRAR'S SIGNATURE <i>Mrs Carrie Luther</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. A.

NOV 13 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10939 CERTIFICATE OF DEATH

10920
24

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN lb 50 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 609 Crain Highway, S.E.		d. STREET ADDRESS 609 Crain Highway, S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ALBERT		First	Middle	Last	4. DATE OF DEATH Nov. 30, 1956	Month	Day	Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 17, 1860	9. AGE (In years last birthday) 96	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Canvas Seller		10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William A. Hamlen		14. MOTHER'S MAIDEN NAME Josephine Hiskey		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Esther Greenwell		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 096.9 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Cardio - Vascular Disease			INTERVAL BETWEEN ONSET AND DEATH 5 days
									10 years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore, Md.		(County) Baltimore Co.	(State) Md.
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>James S. Billingslee</i> M.D. ADDRESS (Street, city or town, state) 108 Central St. Glen Burnie, Md. DATE SIGNED Dec 1/1956									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 3/56		22c. NAME OF CEMETERY OR CREMATORIUM Meadowridge Mem. Pk.		22d. LOCATION (City, town, or county) Howard Co., Maryland		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Teddy V. Langston - Glen Burnie, Md.</i>									
24a. REC'D BY REGISTRAR DEC 4 1956 DATE 24b. REGISTRAR'S SIGNATURE <i>L. J. Hebbag</i>									

WISCONSIN STATE GOVERNMENT OF LIBERTY-BELIEF-LOVE

CONFIDENTIALITY OF INFORMATION

BUREAU V. 2

DEC 4 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10921

10911 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ANNE ARUNDEL		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOULIS		d. STREET ADDRESS 1000 Madison St.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Annapolis, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Stephen Craig HAMMER		First	Middle	Lost	4. DATE OF DEATH November 14 1956	Month	Day	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9 November 1956	9. AGE (In years lost birthday) yrs. 5	IF UNDER 1 YEAR Months 5	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - - -		10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME Roland James HAMMER		14. MOTHER'S MAIDEN NAME Patricia Elaine JETT						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. - - -		17. INFORMANT U.S. Naval Hospital, Annapolis, Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Postnatal asphyxia and atelectasis				INTERVAL BETWEEN ONSET AND DEATH 5 days		
762.5 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO with Immaturity #762.5						
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 13 November 1956 , to 14 November 1956 , that I last saw the deceased alive on 14 November 1956 , and that death occurred at 0805 AM M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Francesco De Paola M.D.						DATE SIGNED 14 Nov. 1956		
ACTUAL SIGNATURE Francesco De Paola								
PHYSICIAN'S NAME (Type) Francesco DE PAOLA LT MC USNR		U.S. Naval Hospital, Annapolis Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 15, 56		22c. NAME OF CEMETERY OR CREMATORIUM Naval Cemetery		22d. LOCATION (City, town, or county) Annapolis, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR J. D. Finch		24b. REGISTRAR'S SIGNATURE		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100% CERTIFICATE OF DEATH
MICHIGAN STATE DEPARTMENT OF HEALTH—BALTIMORE

BUREAU V.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10912 CERTIFICATE OF DEATH

10923

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		
<i>Anne Arundel</i> <i>MARYLAND</i>		<i>Maryland</i> <i>Anne Arundel</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	b. COUNTY	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Annapolis</i>		<i>Anne Arundel</i>	<i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS			
<i>200 South Villa Ave.</i>	<i>200 South Villa Ave.</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First	Middle	Last	
	<i>I</i>	<i>s</i>	<i>Hawkins</i>	
4. DATE OF DEATH	Month	Day	Year	
	<i>11</i>	<i>25</i>	<i>1956</i>	
S. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	
<i>Male</i>	<i>Col.</i>	<i>WIDOWED</i> <input type="checkbox"/> <i>DIVORCED</i> <input type="checkbox"/>	<i>6-30-79</i>	
9. AGE (In years last birthday) yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<i>77</i>	<i>House Man</i>	<i>Hotel</i>	<i>Calvert Co. - Md</i>	<i>U. S. A.</i>
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME			
<i>Henry Hawkins</i>	<i>Louise Kent</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Type, no, or unknown) (If you give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address	
<i>No</i>	<i>202-11-3091A</i>	<i>Cassie Hawkins - Annapolis, Md.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	<i>Heart</i>			
<i>180x</i>	<i>Carcinoma</i>			
DUE TO				
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.				
DUE TO				
(c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
19				
21. I certify that I attended the deceased from <i>9-15-56</i> , 19 <i>.....</i> to <i>11-25-56</i> , 19 <i>.....</i> , that I last saw the deceased alive on <i>11-24-56</i> , 19 <i>.....</i> , and that death occurred at <i>322 Cathedral St</i> , M., from the causes and on the date stated above.	ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <i>E.T. Allen</i>	M.D.		<i>42 Cathedral St</i>	
PHYSICIAN'S NAME (Type)	<i>A T ALLEN</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county)	(State)
<i>Burial</i>	<i>11-29-56</i>	<i>Brewer Hill</i>	<i>Annapolis</i>	<i>Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REG'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE	
<i>William Allen Jr - Annapolis, Md</i>		<i>Nov. 27 1956</i>	<i>J. French</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

87. **PROBLEMS** — **PROBLEMS** — **PROBLEMS** — **PROBLEMS** — **PROBLEMS** — **PROBLEMS**

BUREAU V. L.

NOV 23 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12050

10941 CERTIFICATE OF DEATH

Reg. Dist. No. 78

1. PLACE OF DEATH o. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE MARYLAND Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 2yrs. 3mos. 4days				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. STREET ADDRESS 1738 Brady Avenue				
3. NAME OF DECEASED (Type or print) William		First William	Middle 			
4. DATE OF DEATH Henderson	Month 11	Day 6	Year 19 56			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Not given	8. DATE OF BIRTH 753 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 勞工		10b. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT Hospital Records			
			State Hospital Crownsville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 196X		INTERVAL BETWEEN ONSET AND DEATH 4 months				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. Carcinoma of left jaw		DUE TO (b) DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Aortic insufficiency, Senile Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 	(County) 	(State)
21. I certify that I attended the deceased from 10/17 , 19 56 , to 11/6 , 19 56 , that I last saw the deceased alive on 11/5 , 19 56 , and that death occurred at 11:05 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Crownsville, Md.		DATE SIGNED 11/7/56		
ACTUAL SIGNATURE <i>Lionel McHenry Mapp</i>		M.D.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 11-20-56	22c. NAME OF CEMETERY OR CREMATORIUM 7th St. of Md. Medical	22d. LOCATION (City, town, or county) Baltimore, Md.	(State) md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, II - Annapolis, MD</i>		ADDRESS 17	24a. REC'D BY REGISTRAR DATE 17 1956	24b. REGISTRAR'S SIGNATURE <i>R. M. Joyce</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DETAIN

BUREAU N.Y.

DEC 17 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10924 28

Reg. Dist. No.

10942 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN lb 2yr. 9mos. 17days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City		3 Y O I - 4		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 914 N. Gilmore		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Elizabeth	Middle Ann	Last Holland	4. DATE OF DEATH 11 26 1956	Month 11	Day 26	Year 1956	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1881?	9. AGE (In years last birthday) 75?	IF UNDER 1 YEAR Months --	IF UNDER 24 HRS. Days --	Hours --	Min. --
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME John Holland			14. MOTHER'S MAIDEN NAME Mariah Holland					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records		Crownsville State Hospital Address Crownsville, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. } (b) Arteriosclerotic Heart Disease DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carcinoma of right breast								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. s. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 2/9 , 19 54 , to 11/26 , 19 56 , that I last saw the deceased alive on 11/25 , 19 56 , and that death occurred at 9:10a.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Ludwig Benedict, M.D.</i>								
ADDRESS (Street, city or town, state) Crownsville, Maryland								
DATE SIGNED 11/26/56								
22a. BURIAL, CREMATION, REMOVAL (Specify) 4/29/56		22b. DATE THEREOF 12/11/56		22c. NAME OF CEMETERY OR CREMATORIAL Mt. Calvary		22d. LOCATION (City, town, or county) Baltimore Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Virgil B. Ruggold		ADDRESS 1463 N. Carey St.		24a. REC'D BY REGISTRAR DATE NOV 28 1956		24b. REGISTRAR'S SIGNATURE K. M. Joyce		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE DEPARTMENT OF HEALTH - BIRKMEIER 18

CERTIFICATE OF DEATH

DECEASED'S NAME	AGE	SEX	CAUSE OF DEATH
EDWARD R. HARRIS	52	M	CHRONIC CARDIOPNEUMONIA
ADDRESS	STREET	CITY	STATE
100 W. 11th Street	100 W. 11th Street	Madison	Wisconsin
NAME AND ADDRESS OF DOCTOR	NAME AND ADDRESS OF FUNERAL DIRECTOR	NAME AND ADDRESS OF CEMETERY	NAME AND ADDRESS OF FUNERAL HOME
DR. JAMES H. HARRIS 100 W. 11th Street	WILLIAM H. HARRIS 100 W. 11th Street	WILLIAM H. HARRIS 100 W. 11th Street	WILLIAM H. HARRIS 100 W. 11th Street
INVESTIGATOR'S SIGNATURE			
BUREAU V. S.			
NOV 29 1956			
RECEIVED			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10922

10940 CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	Anne Arundel MARYLAND Riverdale Norwich Rd.	STATE CITY (If outside corporate limits, write RURAL and give nearest town) TOWN	MD COUNTY Anne Arundel Riverdale (if rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS	LENGTH OF STAY (in this place) years	STREET ADDRESS	Norwich Rd.
3. NAME OF DECEASED (Type or Print) Kenneth Lee Hastings Jr		4. DATE OF DEATH NOV 7 - 1956	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH Jan 23, 1908 49 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Landscape -		10b. KIND OF BUSINESS OR INDUSTRY Landscape -	11. BIRTHPLACE (State or foreign country) Balto.
13. FATHER'S NAME N. Earl Hopkins		14. MOTHER'S MAIDEN NAME Lillian Morris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) U.S. #2		16. SOCIAL SECURITY NO. 214-03-2780	
17. INFORMANT & ADDRESS Daughter - Eileen Jane Hopkins Riverdale		18. MEDICAL CERTIFICATION Myocardial INFarction Generalized Arteriosclerosis	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) MYOCARDIAL INFARCTION ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept 1956, to Nov 1956, that I last saw the deceased alive on Nov 1956, and that death occurred at 12:30 AM, from the causes and on the date stated above.			
SIGNATURE Robert R. Helms M.D.		ADDRESS (Street, city, town, state) Severna Park Md	
DATE SIGNED 11-7-56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 11-9-56	NAME OF CEMETERY OR CREMATORIAL Balto. National Cem.	LOCATION (City, town, or county) Baltimore, Maryland
24. REC'D BY REGISTRAR DATE Nov 8, 1956	REGISTRAR'S SIGNATURE L.J. Deallas	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Loring Byers, 5505 Park Hghts. Ave., Baltimore, Maryland	

GRÉAU V.

9951

ΕΛΛΗΝΙΚΗ ΔΗΜΟΚΡΑΤΙΑ

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10913 CERTIFICATE OF DEATH

10925

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis, Md		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Annapolis, Md.		d. STREET ADDRESS 144 Dewey Drive	
3. NAME OF DECEASED (Type or print) First Muriel Middle Joan Last Hubbard		4. DATE OF DEATH 11 Month Day Year 11 11 1956	
5. SEX F 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 9. AGE (In years last birthday) yrs. 11 November 1956		10. IF UNDER 1 YEAR Months Days Hours Min. 5	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Ralph M. Hubbard		14. MOTHER'S MAIDEN NAME Kitty Mae Marshall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 776X (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT U.S. Naval Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> p.m. 19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-11-, 1956, to 11-11-56, 19-56, that I last saw the deceased alive on DOA 11-11-56, 19-, and that death occurred at 5:30 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE M.W. MASON CAPT. MC USN M.D. ADDRESS (Street, city or town, state) DATE SIGNED 11-12-56 PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) 11-12-56		22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIAL ST. MARYS	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Glass & Sons Annapolis, Md.		24a. REC'D BY REGISTRAR DATE 11	
VS A15 (4) 1SM 9/55		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

NAME

ADDRESS

CITY

STATE

ZIP CODE

PHONE NUMBER

TELEGRAM NUMBER

TELETYPE NUMBER

FAX NUMBER

EMAIL ADDRESS

TELEGRAM ADDRESS

TELETYPE ADDRESS

FAX ADDRESS

MAIL ADDRESS

BUREAU U.S.

NOV 14 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10943 CERTIFICATE OF DEATH

10926 24

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be delivered to the funeral director. This page should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Skidmore</i>		c. LENGTH OF STAY IN 1b <i>Rural</i>	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OR INSTITUTION <i>R.T.D. 2 Box 511</i>		e. STREET ADDRESS <i>R.T.D. 2 Box 511</i>	
3. NAME OF DECEASED (Type or print) <i>Walter John Johnson</i>		4. DATE OF DEATH <i>11 14 1956</i>	Month Day Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-4-1885</i>
9. AGE (In years last birthday) <i>71 yrs.</i>		10. IF UNDER 1 YEAR Months Days Hours Min. <i>0 0 0 0</i>	11. IF UNDER 24 HRS. Months Days Hours Min. <i>0 0 0 0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Handyman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Naval Acad</i>	11. BIRTHPLACE (State or foreign country) <i>Skidmore, Md</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Nathan Johnson</i>	
14. MOTHER'S MAIDEN NAME <i>Annie Johnson</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Type, if unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>213-20-2032</i>		17. INFORMANT Address <i>Mary R. Johnson - Skidmore, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intermittent & protracted Aggravated Cardiac</i>		INTERVAL BETWEEN ONSET AND DEATH <i>448 X</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>(b) Advanced and chronic Grade III</i>		DUE TO <i>(c)</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Nov 13, 1956</i> , to <i>Nov 14, 1956</i> , that I last saw the deceased alive on <i>Nov 14, 1956</i> , and that death occurred at <i>511 R.T.D.</i> M, from the causes and on the date stated above.		ADDRESS (Street, city, or town, state) <i>Skidmore</i>	
ACTUAL SIGNATURE <i>H. Richardson</i>		DATE SIGNED <i>11/16/56</i>	
PHYSICIAN'S NAME (Type) <i>William Reese, Jr. - Annapolis, Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-18-56</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Broad Neck</i>		22d. LOCATION (City, town, or county) <i>Skidmore</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, Jr. - Annapolis, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>Nov 20, 1956 L. J. Bellis</i>	
		24b. REGISTRAR'S SIGNATURE	

MARYLAND STATE DEPARTMENT OF HENRY - BALTIMORE '68

CERTIFICATE OF DEATH

DEATH

REAU V. S.

31 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10914 CERTIFICATE OF DEATH

10927

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md.		b. COUNTY A. A.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		d. STREET ADDRESS 106 - 1st Ave., S. W.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hosp.						e. IS RESIDENCE ON A FARM? / YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First WALTER	Middle S.	Last JONES	4. DATE OF DEATH	Month Nov.	Day 11.	Year 19 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct. 7, 1878	9. AGE (In years lost birthday) 78 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clergyman (rtd)		10b. KIND OF BUSINESS OR INDUSTRY Methodist Church		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? Address		
13. FATHER'S NAME J. Edwin Jones		14. MOTHER'S MAIDEN NAME Laura Virginia Laughton						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none	16. SOCIAL SECURITY NO. none	17. INFORMANT Miss Beulah Jones - 19 W. 29th St.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Hyperdial Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Coronary Thrombosis DUE TO Arteriosclerotic Heart Disease								
INTERVAL BETWEEN ONSET AND DEATH 6 hours								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>						
20c. TIME OF INJURY Hour o. p.m. 19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 11/12 , 19 56 , to 11/14 , 19 56 that I last saw the deceased alive on 11/14 , 19 56 , and that death occurred at 1020 A.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE Edward S. Beck							ADDRESS (Street, city or town, state) 41 Southgate Ave. Annapolis MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/17/56		22c. NAME OF CEMETERY OR CREMATORIUM Western Cem.		22d. LOCATION (City, town, or county) Baltimore, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Baile 17 Md		ADDRESS 18		24a. REG'D BY REGISTRAR DATE Nov. 16, 1956		24b. REGISTRAR'S SIGNATURE Wm. J. French		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 16 1956

REGGIE ED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VIS AISC 155 FORM
VS AISC 155 FORM

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**1094 CERTIFICATE OF DEATH**

10928

Reg. Dist. No. 74

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED				
COUNTY	Anne Arundel	STATE	Maryland			
CITY (If outside corporate limits, write RURAL OR end give nearest town)	Length of Stay (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	County Anne Arundel			
TOWN	Rural - Glen Burnie 2 yrs	TOWN	Glen Burnie			
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Boro 285 Rfd #1 Pasadena P.O. Md	STREET ADDRESS	Boro 285 - Rfd #1 Pasadena P.O.			
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH				
(First)	(Middle)	(Month)	(Day)			
Leona	Eileen	Nov.	27			
(Last)	Kirby	(Year)	19 56			
5. SEX	6. COLOR OR RACE	7. SPOUSE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.
Female	White	Separated	Nov. 11, 1884	72	Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY
Housewife		Same		Nova Scotia Dominion of Canada		A.S.A.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES?		
William Haight		Unknown		(Yes, No, or unk.) (If Yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		18. MEDICAL CERTIFICATION		
None		Winona Ryan - Boro 285, Rfd #1 Pasadena, Md.		Respiratory Failure		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			ANTECEDENT CAUSE(S)			INTERVAL BETWEEN ONSET AND DEATH
420.1 IMMEDIATE CAUSE (A)			DUE TO			24 hr.
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last. (B)			DUE TO			26 hr.
(C)			DUE TO			5 yrs
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			21e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			21f. HOW DID INJURY OCCUR?
			21b. PLACE (Home, farm, factory, street, office bldg., etc.)			21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
			21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work Not while at work			21e. INJURY OCCURRED
						21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from 11/25-1956 to 11/27-1956, that I last saw the deceased alive on 11/27-1956, and that death occurred at 8P.M. from the causes and on the date stated above.						
SIGNATURE <i>P.W. Richard M.D.</i> ADDRESS (Street, city, town, state) <i>715 Carter Rd. Glen Burnie</i> DATE SIGNED <i>11/27/56</i>						
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 11-30-1956		NAME OF CEMETERY OR CREMATORIUM Lorraine Cemetery		LOCATION (City, town, or county) Winsor Mill Rd. Baltimore Co. Md.
24. REC'D BY REGISTRAR DATE Nov. 29, 1956		REGISTRAR'S SIGNATURE <i>L.J. Bellamy</i>		25. FUNERAL DIRECTOR'S SIGNATURE George J. Ruth Inc. - 1735 Harford Avenue Baltimore, Md.		

STATE OF CALIFORNIA
DEPARTMENT OF STATE AUDITORS

THE STATE AUDITORS
OF THE STATE OF CALIFORNIA

RECEIVED

RECEIVED BY STATE AUDITOR

RECEIVED

BUREAU V.

OCT 30 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10929

Reg. Dist. No. 24

10945 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Belvedere Md. USA</i>		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>133 C lifton Ave.</i>		d. STREET ADDRESS <i>919 W. Barre St.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>HENRY</i>	Middle <i>August</i>	Last Jr. 4. DATE OF DEATH <i>Kummer</i> 11 14 1956
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-18-1880</i>
9. AGE (In years (lost birthday)) <i>76 yrs.</i>	10. IF UNDER 1 YEAR Months <i>76</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Brakeman Railroad</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Brakeman Railroad</i>	
10c. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>HENRY August Kummer</i>		14. MOTHER'S MAIDEN NAME <i>Ida. Eschelman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Daughter (Mrs J. Lang Arnold Md)</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARCINOMA</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>154X</i>		DUE TO <i>RECTUM</i>	
		DUE TO <i>CARCINOMA</i>	
		DUE TO <i>RECTUM</i>	
INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July</i> , 1956, to <i>11-14</i> , 1956 that I last saw the deceased alive on <i>11-12</i> , 1956, and that death occurred at <i>10 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Francis J. Codd</i>		ADDRESS (Street, city or town, state) <i>SEVERNA PARK MD</i>	
PHYSICIAN'S NAME (Type) <i>Francis J. Codd</i>		DATE SIGNED <i>11-14-56</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11/19/56</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Western Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Schuster & Sons - Balt 17 Nov</i>		24a. REC'D BY REGISTRAR DATE <i>Nov 19 1956</i>	
		24b. REGISTRAR'S SIGNATURE <i>J. Schuster</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

HAWAIIAN STATE DEPARTMENT OF HEALTH - CAPITAL HOME

CERTIFICATE OF DEATH

Name of deceased		Cause of death	
John Doe		Diseased	
Age at time of death		Place where deceased resided	
65 years		Honolulu, Hawaii	
Date of birth		Date of death	
1891		1956	
Occupation		Name of physician	
Retired		Dr. John Doe	
Residence		Name of hospital	
Honolulu, Hawaii		Kapiolani Hospital	
Relationship to deceased		Signature	
Son		John Doe	
Address		Date issued	
Honolulu, Hawaii		NOV 19 1956	
RECEIVED		BUREAU V.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10915 CERTIFICATE OF DEATH

Reg. Dist. No.

10930
21

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis, Md.		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		d. STREET ADDRESS 47 Franklin Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 47 Franklin Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Maurice C Legum		First	Middle	Last	4. DATE OF DEATH November 11, 1956	Month	Doy	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1885	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Proprietor		10b. KIND OF BUSINESS OR INDUSTRY Liquor Store		11. BIRTHPLACE (State or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-14-5890		17. INFORMANT Eva Legum- Wife- same as # 2		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. coronary artery disease (b) DUE TO gen. arteriosclerosis (c)								
INTERVAL BETWEEN ONSET AND DEATH 4 years								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)
21. I certify that I attended the deceased from 7-1 , 19 52 to 11-11 , 19 56 , that I last saw the deceased alive on 11-11-56 , 19 56 , and that death occurred at 13rd St. M. from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) 45 Franklin St., Annapolis, Md.								
DATE SIGNED Edith Roodler M.D.								
ACTUAL SIGNATURE Edith Roodler								
PHYSICIAN'S NAME (Type) Edith Roodler M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 12, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Kneseth Israel Cemetery		22d. LOCATION (City, town, or county) Annapolis, Maryland		
(State)								
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR J. Ormond		24b. REGISTRAR'S SIGNATURE J. Ormond		
DATE								

MASSACHUSETTS DEPARTMENT OF HEALTH—BOSTON 18

CERTIFICATE OF DEATH

NAME	AGE	SEX	DEATH DATE	TIME	CAUSE OF DEATH
WILLIAM H. COOPER	60	M	APRIL 14, 1956	10:30 A.M.	HEART DISEASE
ADDRESS	STREET	CITY	STATE	ZIP	
100 WASHINGTON ST.	BOSTON	MASS.	02108		
RELATIONSHIP	TO DECEASED	NAME	STREET	CITY	STATE
WIFE	EDITH COOPER	100 WASHINGTON ST.	BOSTON	MASS.	02108
DEATH CERTIFICATE NUMBER	DATE ISSUED	ISSUED BY	EXPIRATION DATE		
100-1000000	APRIL 14, 1956	BOSTON	APRIL 14, 1956		

FBI BUREAU

1956

REGEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10945

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10945

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN lb 2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same		d. STREET ADDRESS Same		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 600 First Ave. Marwood				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Georges Wayne Lewis		First	Middle	Last	4. DATE OF DEATH November 1st.	Month	Day	Year 19 56
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/31/16	9. AGE (In years last birthday) 40 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	Days Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Concrete Worker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William D. Lewis		14. MOTHER'S MAIDEN NAME Aldie Davis						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> Navy		16. SOCIAL SECURITY NO. 186-07-8735		17. INFORMANT Mrs. Dorothy Lewis (wife) Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH Sudden						
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Peptic Ulcer		?						
DUE TO (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Gustave H. Faubert, M.D.</i>		DATE SIGNED <i>11/2/156</i>						
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/5/56		22c. NAME OF CEMETERY OR CREMATORIUM Balto. National		22d. LOCATION (City, town, or county) Baltimore, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Home 130 E. Fort Ave. #30		ADDRESS McCully Funeral Home 130 E. Fort Ave. #30		24a. REC'D BY REGISTRAR NOV 5 1956		24b. REGISTRAR'S SIGNATURE <i>L. J. DeLlos</i>		
VS. A15ME(5) 5M 9/55				DATE				

WE ARE PLEASED TO ANNOUNCE THE LAUNCH OF THE NEW STATE OF GUATEMALA
HEALTH INSURANCE PROGRAM.

BUREAU V. S.

1956 5 NOV

RECEIVED
1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10932
74

10947 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lombardee Beach		c. LENGTH OF STAY IN lb Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lombardee Beach		d. STREET ADDRESS Solley, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. 1 Box 202 Lombardee Beach				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Ralph	Middle Samuel	Last Lynn	4. DATE OF DEATH 11 15 19 56	Month 11	Day 15	Year 19 56
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1/27/91	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Checker		10b. KIND OF BUSINESS OR INDUSTRY Atlantic Term.		11. BIRTHPLACE (State or foreign country) Phil., Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alexander Lynn		14. MOTHER'S MAIDEN NAME Mary Schlutter		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Family		Same	
18. CAUSE OF DEATH [Enter only one cause per line for, (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Bronchogenic Carcinoma Lung</i>						INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>142</i>		(b) _____					
DUE TO		DUE TO					
DUE TO		(c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Riviera Beach, Md.	(County) Riviera Beach, Md.	(State) MD
21. I certify that I attended the deceased from July 1955 , to 11/15 1956 , that I last saw the deceased alive on 11/13 1956 , and that death occurred at 5:00 A.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Riviera Beach, Md.		DATE SIGNED 11/16/56	
ACTUAL SIGNATURE <i>J. Brady Smith</i>	PHYSICIAN'S NAME (Type) <i>J. BRADY SMITH</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/17/56	22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cem.	22d. LOCATION (City, town, or county) Baltimore, Md.	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Home		ADDRESS 130 E. Fort Ave. #30	24a. REC'D BY REGISTRAR NOV 19 1956	24b. REGISTRAR'S SIGNATURE <i>L. J. Deallay</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE DEPARTMENT OF HEALTH - SECTION 18

CERTIFICATE OF DEATH

BUREAU V. S.
NOV 18 1950
RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10933

10933 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. STREET ADDRESS 54 Southgate Ave.	
3. NAME OF DECEASED (Type or print) ESTHER MANDELSTAN		4. DATE OF DEATH NOVEMBER 16 1956	Month Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH October 6, 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Lithuania
13. FATHER'S NAME Louis Kaplan		14. MOTHER'S MAIDEN NAME Tobie Benjamin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Mrs Louis M. Strauss- Daughter- same as # 2
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. 420.1 (b) Arteriosclerotic cardiovascular disease DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 11 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11/16 , 19 56 , to 11/16 , 19 56 , that I last saw the deceased alive on 11/16 , 19 56 , and that death occurred at 825 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hagerstown, Maryland DATE SIGNED 11/17/56			
ACTUAL SIGNATURE John L. Hedeman		M.D.	
PHYSICIAN'S NAME (Type) John Hedeman		90 Cathedral Street Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11- 18- 56	22c. NAME OF CEMETERY OR CREMATORIAL B'nai Abraham Cemetery
22d. LOCATION (City, town, or county) Hagerstown, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME		24a. REC'D BY REGISTRAR J. P. Hopping	24b. REGISTRAR'S SIGNATURE J. P. Hopping
ADDRESS Annapolis, Maryland		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the funeral director.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

CERTIFICATE OF DEATH

MAY 21, 1956

JUN 21 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10934

10948 CERTIFICATE OF DEATH

Reg. Dist. No.

28

1. PLACE OF DEATH o. COUNTY Anne Arundel County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland		b. COUNTY Baltimore City				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN lb 10½ months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City		3 Vol - 4				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 460 Oxford Court		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Ronald		First	Middle	Last	4. DATE OF DEATH 11	Month	Day	Year		
5. SEX Male		6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 10/6/48	9. AGE (In years last birthday) 8 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.				
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Katrina Massdin								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -----		16. SOCIAL SECURITY NO. -----		17. INFORMANT Crownsville State Hospital, Md.		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X		Purulent Bronchiolitis bilaterally		INTERVAL BETWEEN ONSET AND DEATH one week						
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) Paraplegia								
(c) Chronic Brain Syndrome associated with Convulsive Disorder										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none								
20c. TIME OF INJURY Hour o. m. ----- p. m. -----		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) -----		(County)	(State)	
21. I certify that I attended the deceased from Nov. 30, 1956, to Nov. 30, 1956, that I last saw the deceased alive on Nov. 30, 1956, and that death occurred at 3:35 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. Crownsville State Hospital, Md.							DATE SIGNED			
ACTUAL SIGNATURE <i>Ludwig Benedict</i>		PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D.		Crownsville, Md.					12/1/56	
22a. BURIAL Cremation, Removal (Specify) Dec. 4-56 Mt. Auburn Cemetery		22b. DATE THEREOF 12/4/56		22c. NAME OF CEMETERY OR CREMATORIAL Mt. Auburn Cemetery		22d. LOCATION (City, town, or county) Baltimore		(State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>François Henry</i>		ADDRESS 578 W. Bidwell		24a. RECEIVED BY REGISTRAR Dec. 3, 1956		24b. REGISTRAR'S SIGNATURE <i>R. W. Joyce</i>				

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

Form No. 60

NAME

DECEASED

BUREAU V. S.

DEC 4 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10935

10949 CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 14 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Irene	Middle McCray	4. DATE OF DEATH 11 16 19 56
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH S.C. 9. AGE (In years from birth day) 30 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	10c. BIRTHPLACE (State or foreign country) S.C.
11. CITIZEN OF WHAT COUNTRY?		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Richard Padden		14. MOTHER'S MAIDEN NAME Eloise Padden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pyelonephritis with Uremia DUE TO 600.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 07-1 (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Cardiovascular Disease, Syphilis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/3 1956 to 11/16 19 56 , that I last saw the deceased alive on 11/15 19 56 , and that death occurred at 9:30a. M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 11/16/56	
ACTUAL SIGNATURE Lionel McHenry Mapp		PHYSICIAN'S NAME (Type) Lionel McHenry Mapp	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 20th	
22c. NAME OF CEMETERY OR CREMATORIAL Mt Calvary Cemetery		22d. LOCATION (City, town, or county) Berwyn (State) IL	
23. FUNERAL DIRECTOR'S SIGNATURE Elroy Wilson		ADDRESS 1000 Grandlawn Dr.	
24. REC'D BY REGISTRAR DATE 1138-56		24b. REGISTRAR'S SIGNATURE Kathleen M. Jayce	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MATERIALS STATE GOVERNMENT OF HAWAII - BALTIMORE, MD

CERTIFICATE OF DEATH

Date:

Name of deceased:

Address:

Cause of death:

Name of physician:

Name of hospital:

Name of funeral home:

Name of coroner:

Name of pathologist:

Name of laboratory:

Name of medical examiner:

Name of attorney:

Name of coroner's office:

FBI BUREAU V.

JULY 23 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10936

Reg. Dist. No.

CERTIFICATE OF DEATH

10917

1. PLACE OF DEATH a. COUNTY <i>a.a.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	c. LENGTH OF STAY IN 1b <i>General</i>	b. COUNTY <i>a.a.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>General</i>	d. STREET ADDRESS <i>15 Locust Ave</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Eugenio M. Medford</i>	First <i>Eugenio</i>	Middle <i>M.</i>	Last <i>Medford</i>		
4. DATE OF DEATH <i>11-1-1956</i>	Month <i>11</i>	Day <i>1</i>	Year <i>1956</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-12-1878</i>		
9. AGE (In years last birthday) <i>78 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Catonsville, Baltimore Co., Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		
13. FATHER'S NAME <i>John J. Fisher</i>	14. MOTHER'S MAIDEN NAME <i>Ellenora Bennix</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			
16. SOCIAL SECURITY NO. <i>- - -</i>	17. INFORMANT <i>Jesse L. Medford</i>	Address <i>(2)</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Lack of Living</i> DUE TO <i>163X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <i>6 mos +</i>					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) <i>Baltimore</i>	(County) <i>Md.</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>8/12</i> , 19 <i>56</i> , to <i>11/1</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>11/1</i> , 19 <i>56</i> , and that death occurred at <i>6:05 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Annapolis, Md.</i>					
ACTUAL SIGNATURE <i>Maurice Klawans</i>	DATE SIGNED <i>11/1/56</i>				
PHYSICIAN'S NAME (Type) <i>MARICE F. KLAWANS</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11-5-1956</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Barkwood Cemt</i>	22d. LOCATION (City, town, or county) <i>Baltimore</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i>	ADDRESS <i>Annapolis, Md.</i>	24a. REC'D BY REGISTRAR DATE <i>11/1/56</i>			
				24b. REGISTRAR'S SIGNATURE <i>John M. Taylor</i>	

DEPARTMENT OF DEFENSE - GENEVA CONVENTION
CERTIFICATE OF DEATH

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RECEIVED
NOV 7 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10937
24

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		10950 <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		MD <i>A.A.</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <i>Arnold. 36 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS <i>Arnold. MD</i>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		<i>Dividing Cr. Rd.</i>		d. STREET ADDRESS <i>Div. Cr. Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <i>William</i>	Middle <i>Henry</i>	Last <i>Moog</i>	4. DATE OF DEATH <i>11-12-56</i>	Month Day Year 11 12 56	5. SEX <i>M.</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <i>Jan 28, 1875</i>	8. DATE OF BIRTH <i>1875/1/28</i>	9. AGE (In years lost birthday) yrs. <i>81 yrs</i>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Store Keeper Grocery</i>		11. BIRTHPLACE (State or foreign country) <i>Chicago, Ill.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>							
13. FATHER'S NAME <i>Herman Moog</i>		14. MOTHER'S MAIDEN NAME <i>W. Zimmerman</i>		Address <i>wife mrs moog - Arnold moog</i>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16. SOCIAL SECURITY NO. <i>200</i>		17. INFORMANT <i>Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 yrs.</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>145X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>(b)</i> DUE TO <i>(c)</i>		Carcinoma Tonsil.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour o. g. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Severna Park</i>		20f. (City or town) <i>Severna Park</i>	(County) <i>Severna Park</i>	(State) <i>Severna Park</i>	
21. I certify that I attended the deceased from <i>1956</i> , 19, to <i>Nov 12</i> , 1956, that I last saw the deceased alive on <i>10 Nov 56</i> , 19, and that death occurred at <i>8:20 AM</i> , from the causes and on the date stated above.		ACTUAL SIGNATURE <i>Robert R. Hahn</i>		ADDRESS (Street, city or town, State) <i>Severna Park</i>		DATE SIGNED <i>11-12-56</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-16-56</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Western Cemetery</i>		22d. LOCATION (City, town, or county) <i>Baltimore</i>		(State) <i>Baltimore</i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Cook, Inc., 1217 St. Paul Street</i>		ADDRESS <i>William Cook, Inc., 1217 St. Paul Street</i>		24a. REC'D BY REGISTRAR <i>L. J. DeAlbay</i>		24b. REGISTRAR'S SIGNATURE <i>L. J. DeAlbay</i>		DATE <i>Nov. 14, 1956</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

81 ЗНОМІДЛЯННЯ ЗО ТВЕРДІАСТІЮ ВІДРАДИ

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for you.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A1SME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										10939	
10951 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 27	
1. PLACE OF DEATH a. COUNTY Anne Arundel					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Baltimore						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft. Meade			c. LENGTH OF STAY IN 1b 6 Hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus, Baltimore 27.			d. STREET ADDRESS 1230 Taylor Avenue			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ft. Meade Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Frances		First	Middle	Last	4. DATE OF DEATH Neighoff, 11	Month	Day	Year			
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 7/4/07	9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.		
8. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Baltimore, Md.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Francis M. Neighoff 11					14. MOTHER'S MAIDEN NAME Elizabeth Schanken						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-16-6636		17. INFORMANT Mrs Catherine Neighoff, same as 2		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion										INTERVAL BETWEEN ONSET AND DEATH sudden	
DUE TO Conditions, if any, which gave rise to immediate cause (a) (b)											
DUE TO Conditions, if any, which gave rise to underlying cause (b) (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Gustave H. Faubert M.D.</i>										DATE SIGNED Nov. 9, 1956	
EXAMINER'S NAME (Type) Gustave H. Faubert		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 9, 1956		22c. NAME OF CEMETERY OR CREMATORIAL Sandown Park		22d. LOCATION (City, town, or county) Baltimore		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Frederick A. Cole, 1913 W. Baltimore St.</i>		ADDRESS		24a. REC'D BY REGISTRAR W. J. Taylor		24b. REGISTRAR'S SIGNATURE <i>J. M. Taylor</i>		DATE Nov. 9, 1956			

BUREAU V. S.

NOV 13 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10952 CERTIFICATE OF DEATH

Reg. Dist. No. 10940

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY <i>MARYLAND</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>DA</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>WEST RIVER</i>	c. LENGTH OF STAY IN lb <i>81 yrs.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>WEST RIVER</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>HOWARD PEARKE</i>	First	Middle	Last
4. DATE OF DEATH <i>Nov 4 1956</i>	Month	Day	Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MARS 1875</i>
9. AGE (In years lost birthday) <i>81 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Tobacco</i>	11. BIRTHPLACE (State or foreign country) <i>WEST RIVER</i>	12. CITIZEN OF WHAT COUNTRY? <i>Mrs Mary Nutwell West River Md.</i>
13. FATHER'S NAME <i>WM H. Penke</i>	14. MOTHER'S MAIDEN NAME <i>Virginia Sanders</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>- - -</i>	17. INFORMANT <i>Dr. Mary Nutwell</i>	Address <i>West River Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma Prostatec metastasis</i>			
DUE TO <i>179x</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____			
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. <i>19</i> p. m. _____	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <i>West River</i> (County) <i>MD</i> (State) <i>Md.</i>
21. I certify that I attended the deceased from <i>waterloo</i> , 19 <i>56</i> , to <i>Nov 4</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Nov 4</i> , 19 <i>56</i> , and that death occurred at <i>12:30 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>West River Md.</i> DATE SIGNED <i>1956</i>			
ACTUAL SIGNATURE <i>Howard Penke</i>		PHYSICIAN'S NAME (Type) <i>Howard Penke</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Nov 6/56</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Christ church</i>	22d. LOCATION (City, town, or county) <i>West River</i> (State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard Hardisty</i>	ADDRESS <i>Gilsville Md.</i>	24a. REC'D BY REGISTRAR <i>J. J. Smith</i>	24b. REGISTRAR'S SIGNATURE <i>J. J. Smith</i>

956 9 ROM

REGELIV ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10941

10918 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A A</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>A A</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Anne Arundel</i>	c. LENGTH OF STAY IN 1b <i>3 days</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Deale</i>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Anne Arundel General</i>		d. STREET ADDRESS							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)	First <i>DELMA</i>	Middle <i>VIRGINIA</i>	Last <i>Phipps</i>						
4. DATE OF DEATH	Month <i>Nov</i>	Day <i>11</i>	Year <i>1956</i>						
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/13/11</i>						
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <i>45 yrs.</i>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY							
11. BIRTHPLACE (State or foreign country) <i>Chorlton Md</i>		12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <i>Louis Blane Phipps</i>		14. MOTHER'S MAIDEN NAME <i>Clara Delma Rogers</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>							
17. INFORMANT <i>Nevitt Phipps Deale, Md</i>		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> 332X DUE TO		<i>2 days</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral Arteriosclerosis</i> DUE TO		<i>unknown</i>							
(c) <i>Arteriosclerosis, generalized</i>		<i>unknown</i>							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Coronary Arteriosclerosis & myocardial insufficiency</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Hour <i>a. m.</i> <i>19</i>		Month <i>Day</i>	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <i>11/11/1956</i> , to <i>11/11/1956</i> , that I last saw the deceased alive on <i>11/11/1956</i> , and that death occurred at <i>5:30 A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED					
ACTUAL SIGNATURE <i>Edward S. Beck</i>		M.D. <i>44 Southgate Ave, Annapolis, Md</i>							
PHYSICIAN'S NAME (Type) <i>EDWARD S. BECK MD</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/13/56</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Zucker</i>	22d. LOCATION (City, town, or county) <i>Annapolis</i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard Hardisty, Galveston, Md</i>		ADDRESS <i>Bernard Hardisty, Galveston, Md</i>		24a. REC'D BY REGISTRAR DATE <i>J. J. - 10/10/56</i>	24b. REGISTRAR'S SIGNATURE <i>J. J. - 10/10/56</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

John Doe

Hazard

State of New York

NAME OF DECEASED	AGE	SEX	CAUSE OF DEATH
JOHN DOE	35	M	TOOK TOO MUCH COCAINE
DEATH CERTIFIED BY		DOCTOR	DEATH CERTIFIED BY
JOHN DOE		DR. JOHN D. HAZARD	DR. JOHN D. HAZARD
LAW ENFORCEMENT OFFICER		DEATH CERTIFIED BY	DEATH CERTIFIED BY
JOHN DOE		OFFICER JOHN D. HAZARD	OFFICER JOHN D. HAZARD
RECEIVED		RECEIVED	RECEIVED
NOV 16 1956		NOV 16 1956	NOV 16 1956
BUREAU V. 8		BUREAU V. 8	
RECEIVED		RECEIVED	
NOV 16 1956		NOV 16 1956	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10942

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <i>ANNE ARNDL</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>SEVERNA PARK MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>HANNAH POLIS MD</i>		c. LENGTH OF STAY IN lb <i>15 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>ANNE ARNDL</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>MINNIE PORTER</i>		First	Middle
		Last	4. DATE OF DEATH <i>11 18 1956</i>
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/16/1893</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSE WIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>NEW JERSEY</i>
13. FATHER'S NAME <i>NOT KNOWN</i>		14. MOTHER'S MAIDEN NAME <i>NOT KNOWN</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	17. INFORMANT <i>MRS AGNES DAILEY NORTH WARD</i>
		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Congestive Heart Failure Aute</i>		(c) DUE TO <i>Hypertensive Arteriosclerotic Cardiovascular Disease 4 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Leukemia chronic</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>White at work</i>	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JAN.</u> , 19 <u>56</u> , to <u>3:54 P.M.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11-17</u> , 19 <u>56</u> , and that death occurred at <u>Severna Park</u> , MD, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Francis L. Colle</i> PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state) <i>Severna Park MD</i> DATE SIGNED <i>11-18-56</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11/21/56</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Severna Park Nat.</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore City</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Talcott & Son</i>		24a. REC'D BY REGISTRAR DATE <i>11-21-56</i>	24b. REGISTRAR'S SIGNATURE <i>Dr. Wm. French</i>

WISCONSIN STATE DEPARTMENT OF HEALTH - SANITATION

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	DEATH DATE	TIME	CAUSE OF DEATH	DEATH CERTIFIED
C. E. GELIVE		M	NOV. 21, 1956	10:00 A.M.	HEART DISEASE	BY DOCTOR
ADDRESS	STREET	CITY	STATE	ZIP	PHONE NUMBER	REGISTRATION NO.
100 N. 10th Street		Madison	Wisconsin	53701	(608) 255-1234	1234567890
I declare under penalty of perjury that the information contained in this certificate is true and correct.						
REAU V. S.						
NOV. 21, 1956						
EGELIVE						

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10953 CERTIFICATE OF DEATH

Reg. Dist. No.

10943

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City		3. VOA-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 528 N. Carrollton Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Viola	Middle	Last Randolph	4. DATE OF DEATH 11 27 1956	Month	Day	Year
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 9/20/93	9. AGE (In years lost birthday) 63 yrs.	IF UNDER 1 YEAR Months - Days -	IF UNDER 24 HRS. Hours - Min. -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Unk.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John Randolph			14. MOTHER'S MAIDEN NAME Annie Randolph				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records		Crownsville State Hospital Address Crownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute renal failure 446 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Hypertensive Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hepatomegaly with Ascites							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/24 , 19 56 , to 11/27 , 19 56 , that I last saw the deceased alive on 11/26 , 19 56 , and that death occurred at 2:55 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Lionel McHenry Mapp</i> ADDRESS (Street, city or town, state) Crownsville, Maryland DATE SIGNED 11/27/56							
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp							
22a. BURIAL, CREMATION, REMOVAL (Specify) 1/26/56	22b. DATE THEREOF 1/26/56	22c. NAME OF CEMETERY OR CREMATORIUM Mt Auburn		22d. LOCATION (City, town, or county) (State) Baltimore Md			
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. Halstead 918 Dund Hurst</i>		ADDRESS <i>100 Halstead 918 Dund Hurst</i>		24a. REC'D BY REGISTRAR DATE 12/4/56		24b. REGISTRAR'S SIGNATURE <i>J. M. Joyce</i>	

WISCONSIN STATE DEPARTMENT OF NATURAL RESOURCES

RECEIVED **BUREAU V. S.**
EC 5 1956

1956 5 2

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AFSC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10944

10951 CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH

COUNTY	Anne Arundel	
CITY (if outside corporate limits, write RURAL or end give nearest town)	Maryland	
TOWN	Pasadena MD	LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Ritchie Highway Pasadena Ind.	

**3. NAME OF DECEASED
(Type or Print)**

(First)	(Middle)	(Last)
Mattie K. Reich		

5. SEX

F.

6. COLOR OR RACE

W.

**7. SINGLE, MARRIED, WIDOWED, DIVORCED,
(Specify)**

SINGLE, MARRIED,

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE	MD	COUNTY	A.A.
CITY (if outside corporate limits, write RURAL and give nearest town)	Pasadena MD		
TOWN	Pasadena		
STREET ADDRESS	Ritchie Highway.		

8. DATE OF BIRTH

Nov 27, 1883

9. AGE last birthday

72 yrs.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

House

11. BIRTHPLACE (State or foreign country)

Baltimore County

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Thomas P. West

14. MOTHER'S MAIDEN NAME

Jane Beeler

**15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.)**

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.**17. INFORMANT & ADDRESS**Daughter
Mrs Bauer - Pasadena Md**18. MEDICAL CERTIFICATION****I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH**

260x IMMEDIATE CAUSE

(A)

DUE TO

ANTECEDENT CAUSE(S) DUE TO

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE

(C)

STATING UNDERLYING CAUSE LAST.

DUE TO

(D)

DUE TO

(E)

DUE TO

(F)

DUE TO

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UREAU V. S.

1956 6 NOV.

RECEIVE

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transcript.

V5 A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.**10955 CERTIFICATE OF DEATH**

10945

28

Reg. Dist. No.....

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Anne Arundel Millersville Sann's Nursing Home	MARYLAND LENGTH OF STAY (in this place)	Maryland 416 Sixth Ave., N.E. (If rural give location)
		Anne Arundel	
		STATE COUNTY	
		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
		STREET ADDRESS	
		Glen Burnie,	
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)	
EDITH		November 26, 1956	
(First)	(Middle)	(Last)	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Female	White	Single	Aug. 11, 1895
9. AGE last birthday yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Deys	12. Hours
61			
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Sec. (ret.)		U.S.Civil Serv.	St. Mary's County, Md.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Richard B. Sanner		Nancy T. Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
no		none	
17. INFORMANT & ADDRESS		517 Park Ave.	
Mr. Carroll Sanner Towson, Md.			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <i>170x</i> (A) <i>Carcinoma breast</i>		11 mos	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19e. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
M.		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Sept. 19, 1956</i> , to <i>Nov. 28, 1956</i> , that I last saw the deceased alive on <i>Oct. 23, 1956</i> , and that death occurred at <i>8:45 AM</i> , from the causes and on the date stated above. SIGNATURE <i>Carroll Carroll MD</i> M.D. ADDRESS (Street, city, town, state) <i>Glen Burnie, Md.</i> DATE SIGNED <i>11-27-56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
Burial		11/29/56	
24. REC'D BY REGISTRAR		NAME OF CEMETERY OR CREMATORIAL REGISTRAR'S SIGNATURE	
NOV 28 1956		Woodlawn	
DATE		LOCATION (City, town, or county) (State)	
25. FUNERAL DIRECTOR'S SIGNATURE		Woodlawn, Maryland	
Z. M. Joyce		ADDRESS	
P. J. Langston - Glen Burnie, Md.			

MURRAY

NOV 28 1956

REGELIV ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10946

10955 CERTIFICATE OF DEATH

Reg. Dist. No. 24

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Md		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Severna Park 35 yrs		b. COUNTY		Anne Arundel		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cedar Rd - Carrollton Manor				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park Md				
3. NAME OF DECEASED (Type or print) Aldewin Wesley Sappington		First	Middle	Last	4. DATE OF DEATH 20 Nov.	Month	Day	Year 19 56
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 5 - 1882 74 yrs.	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Boat repair		11. BIRTHPLACE (State or foreign country) Anne Arundel County		12. CITIZEN OF WHAT COUNTRY U.S.		
13. FATHER'S NAME Harmon Sappington		14. MOTHER'S MAIDEN NAME Anna Boozer						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 220-16-490		17. INFORMANT Severna Park Son Aldewin Wesley Sappington				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1		DUE TO Cerebral						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b)		DUE TO Atherosclerotic C. V. Disease						
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)
21. I certify that I attended the deceased from 1955, 19 Nov., to 1956, 19 Nov., that I last saw the deceased alive on Nov 19-56, and that death occurred at 8:30 AM, from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		
ACTUAL SIGNATURE Robert R. Hahn M.D.						DATE SIGNED 11-20-56		
PHYSICIAN'S NAME (Type) Robert R. Hahn								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/24/56		22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill		22d. LOCATION (City, town, or county) Balto. 25		(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Gamps & Kirkley		ADDRESS Hopping and Kirkley, Glen Burnie, Md.		24a. REC'D BY REGISTRAR NOV 26 1956		24b. REGISTRAR'S SIGNATURE L. J. de Alba		

10 DEPARTMENT OF DEFENSE - CALIFORNIA

U.S. CERTIFICATE OF DEATH

BUREAU X.

NOV 26 1956

RECEIVED

MARYLAND

STATE DEPARTMENT OF HEALTH

10947

10957 CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH COUNTY <u>Anne Arundel</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Arnold</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Arnold</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Dividing Cr. Rd.</u>		STREET ADDRESS <u>Dividing Cr Rd.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Carrie</u>	(Middle) <u>T.</u>	(Last) <u>Schriever</u>
4. DATE OF DEATH	(Month) <u>Nov.</u>	(Day) <u>9</u>	(Year) <u>1957</u>
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>F.</u>	<u>W.</u>	<u>1908-1875</u>	<u>81</u> , yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> .	9. AGE last birthday If under 1 year Months. <u>0</u>	If under 24 hrs. Hours <u>0</u>
13. FATHER'S NAME <u>John</u>	14. MOTHER'S MAIDEN NAME <u>John</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS <u>Daughter, Mrs. Bush. (Div. Creek Rd S. P.)</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>42</u>		18. MEDICAL CERTIFICATION <u>Acute Pulmonary Edema.</u>	
Immediate cause <u>Arteriosclerotic C. V. Disease</u>		Antecedent cause(s) <u>Diseases or conditions, if any, giving rise to the above cause</u>	
		<u>stating the underlying cause last</u>	
		(c) <u>Arteriosclerotic C. V. Disease</u>	
II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
21. ACCIDENT SUICIDE HOMICIDE	(Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) TIME (Month) (Day) (Year) (Hour) OF INJURY m. INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	(CITY OR TOWN) (CITY OR TOWN) HOW DID INJURY OCCUR?	
		(CITY OR TOWN) (CITY OR TOWN)	

22. I hereby certify that I attended the deceased from <u>1955</u> , to <u>now</u> , 19 <u>57</u> that I last saw the deceased alive on <u>Oct 10</u> , 19 <u>56</u> and that death occurred at <u>12:00 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>Robert R. Hahn, M.D.</u> ADDRESS <u>Severna Park Md</u> DATE SIGNED <u>11-12-56</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>11-12-56</u>	NAME OF CEMETERY OR CREMATORIAL <u>Bethesda Cemetery</u>	LOCATION (City, town, or county) <u>Baltimore Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR	ADDRESS <u>John M. Taylorson Annapolis Md</u>

RECEIVED
BUREAU X-2

OCT 14 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 5, 6, 7 FILED 12-18-56 et

10948

10958 Items 13, 14 FILED 12-20-56 et
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Anne Arundel, MARYLAND		Maryland AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Shady Side 834		Shady Side -	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Lost		4. DATE OF DEATH Month Day Year	
James Albert Scott		November 10 1956	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH DEC 9 1873
			9. AGE (In years last birthday) 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Oyster	
11. BIRTHPLACE (State or foreign country) Shady Side		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Scott		14. MOTHER'S MAIDEN NAME Matilda Thompsons	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		Heart failure—Coronary Occlusion 2 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		Arteriosclerosis. 5 years	
DUE TO (b)		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Hypertension	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from alive on _____, and that death occurred at 2:00 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE		Franklin D Hendricks Shady Side, Maryland 11-11-56	
PHYSICIAN'S NAME (Type)		Franklin D Hendricks Shady Side, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/13/56	
22c. NAME OF CEMETERY OR CREMATORIAL Scotts		22d. LOCATION (City, town, or county) Shady Side	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Hendricks		ADDRESS	
24a. REC'D BY REGISTRAR 100		24b. REGISTRAR'S SIGNATURE	
DATE			

MANHATTAN STATE OBSERVATION - BUREAU - 18

CERTIFICATE OF DRAW

BUREAU V. E

NOV 16 195

REGELIVEL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10949

10920 CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE			
<i>Anne Arundel Maryland</i>		<i>Maryland a. d. co.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	b. COUNTY			
<i>Annapolis</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
<i>A. D. General Hosp.</i>	<i>Annapolis</i>				
3. NAME OF DECEASED (Type or print)	First	Middle	Last		
<i>Robert</i>			<i>R. Sharps</i>		
4. DATE OF DEATH	Month	Day	Year		
	11	6	19 56		
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) IF UNDER 1 YEAR 38 yrs.	IF UNDER 24 HRS. Months Days Hours Min.
<i>Male</i>	<i>Col.</i>	<input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	<i>11-28-1917</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<i>Laborer</i>				<i>Annapolis, Md.</i>	
12. CITIZEN OF WHAT COUNTRY?		<i>U.S.A.</i>			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
<i>Robert W. Sharps</i>		<i>Carrie E. Turner</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, do not know) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
<i>No</i>		<i>213-12-9070</i>		<i>Carrie E. Turner - 47 Dean St. Annapolis, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Fever Adenitis Bacillus & Nucle Mandibular 1 mo.</i>			
199.8 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		DUE TO <i>Class IV</i>			
{ (b)		DUE TO			
{ (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6/25</i> , 1956, to <i>11/6</i> , 1956, that I last saw the deceased alive on <i>11/6</i> , 1956, and that death occurred at <i>12:50 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE <i>Theodore H. Johnson</i>		DATE SIGNED <i>37 Cabell Street</i>			
PHYSICIAN'S NAME (Type) <i>Dr. THEODORE H. JOHNSON</i>		<i>Annapolis, Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-9-56</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Brewer Hill</i>	
22d. LOCATION (City, town, or county) <i>Annapolis, Md.</i>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, II - Annapolis, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR <i>NOV 13 1956</i>	
				24b. REGISTRAR'S SIGNATURE <i>J. French</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, copy the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE GOVERNMENT OF HAMILTON - 1919

CERTIFICATE OF DEATH

FBI
RECEIVED
NOV 13 1955

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10950

10959 CERTIFICATE OF DEATH

Reg. Dist. No. 74

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M —

1. PLACE OF DEATH COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL OR end city nearest town) TOWN GLEN BURNIE		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS PLAZA MANOR COMM. HOME		STREET ADDRESS 2246 Madison Ave.	
3. NAME OF DECEASED (Type or Print) MARY (Corporal) SMITH		4. DATE (Month) (Day) (Year) Nov 16 1956	
5. SEX F	6. COLOR OR RACE C	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH Dec 25
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME Unknown		11. BIRTHPLACE (State or foreign country) Baltimore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		14. MOTHER'S MAIDEN NAME Sadie Ridgeway	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Ernest Smith	
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Bronchopneumonia			
IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
Diabetes Mellitus			
Hypertension			
INTERVAL BETWEEN ONSET AND DEATH			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19e. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov 14 1956 to Nov 16 1956 , that I last saw the deceased alive on Nov 14 1956 and that death occurred at 3:30 A.M. from the causes and on the date stated above.			
SIGNATURE John J. FALER		ADDRESS (Street, city, town, state) 1083 Bolton St., Baltimore, Md.	
DATE SIGNED Nov. 16, 1956		DATE SIGNED Nov. 16, 1956	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 11-19-56	
NAME OF CEMETERY OR CREMATORIAL MT. AUBRYN		LOCATION (City, town, or county) BALTIMORE MD	
24. REC'D BY REGISTRAR DATE NOV 20 1956		REGISTRAR'S SIGNATURE L. J. DeLay	
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. A. Jackson Inc. 916 Pennsylvania Ave.			

U.S. GOVERNMENT PRINTING OFFICE: 1956 20-1000

CERTIFICATE OF DEATH

DECEASED PERSON

NAME AND ADDRESS OF FUNERAL HOME

DATE OF DEATH

TIME OF DEATH

AGE

SEX

RACE

RELIGION

EDUCATION

EMPLOYMENT

RESIDENCE

CAUSE OF DEATH

DEATH CERTIFICATE NUMBER

DEATH DATE

DEATH TIME

DEATH PLACE

DEATH ADDRESS

RECEIVED
MAY 20 1956
DECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10951

1092 CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	A. A. Co. COUNTY STREET ADDRESS		
Anne Arundel Annapolis	MARYLAND 10 days	MD. Annapolis, MD.	Best Gate		
HOSPITAL OR INSTITUTION OR STREET ADDRESS	A.A. GENERAL Hosp.				
3. NAME OF DECEASED (First) SARAH (Middle) ELLEN (Last) Smith			4. DATE OF DEATH 11 12 1956		
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH 12/13/1886	9. AGE last birthday 69 yrs.	IF UNDER 1 YEAR Months Deys Hours Min.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. SEARS			14. MOTHER'S MAIDEN NAME MARY Wood		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS THOMAS A. Smith #2	18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.					
420.1 IMMEDIATE CAUSE (A) Posterior Myocardial infarction		ANTECEDENT CAUSE(S) DUE TO (B) Coronary artery disease		INTERVAL BETWEEN ONSET AND DEATH 6 1/2 h.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)				4 yr	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from March 1953, to November 1956, that I last saw the deceased alive on November 11, 1956, and that death occurred at 2:30 P.M. from the causes and on the date stated above.					
SIGNATURE Frank M. Shugley ADDRESS (Street, city, town, state) DATE SIGNED					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 11/14/56		NAME OF CEMETERY OR CREMATORIUM EDWARDS CHAPEL	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE U. S. Marsh		LOCATION (City, town, or county) Annapolis (State) MD.	
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John W. Gandy & Sons Annapolis, MD.					
DATE					

DEPARTMENT OF HEALTH-SANITATION

CERTIFICATE OF DEATH

REGISTRATION NUMBER TO OCCUPANT

REGISTRATION
NUMBER
TO OCCUPANT

REGISTRATION
NUMBER

REGISTRATION NUMBER TO OCCUPANT

BUREAU V. S.

NOV 16 1956

RECEIVED
STATES

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10952

10960 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 7 yrs. 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Turner's Station, Baltimore 22,	
3. NAME OF DECEASED First Melvin Middle Last Sorrell		d. STREET ADDRESS 627 Maine Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/1/19 9. AGE (In years last birthday) 37 yrs. IF UNDER 1 YEAR Months — Days — Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown 11. BIRTHPLACE (State or foreign country) Virginia 12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Julian Sorrell		14. MOTHER'S MAIDEN NAME Anne Robinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.	16. SOCIAL SECURITY NO. Unk.	17. INFORMANT Hospital Records	Crownsville State Hospital Address Crownsville, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Renal Failure, arteriosclerotic DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Dehydration and Malnutrition			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from alive on _____ and that death occurred at _____, to _____, that I last saw the deceased alive on _____, and that death occurred at _____, M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Lionel McHenry Mapp.	M.D. Crownsville, Maryland		11/13/56
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/20/56	22c. NAME OF CEMETERY OR CREMATOR Y M. J. Oberon Cemetery	22d. LOCATION (City, town, or county) Beltsville MD. (State)
23. FUNERAL DIRECTOR'S SIGNATURE E. Rabbe & Son		ADDRESS	24a. REC'D. BY REGISTRAR- DATE Nov 19 1956
			24b. REGISTRAR'S SIGNATURE X. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be signed by the funeral director. Page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BY ENDOWMENT—DASH TO THE FINISH STATE GRAND RAPIDS

BUREAU V.

1956 Oct 20.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10961 CERTIFICATE OF DEATH

10953

Reg. Dist. No. 28

1. PLACE OF DEATH o. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 3 yrs. 4 mos. 24 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
3. NAME OF DECEASED (Type or print) Ida Moore		d. STREET ADDRESS 3806 Fear Avenue	
4. DATE OF DEATH 11 13 1956		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/6/76
9. AGE (In years lost birthday) 80 yrs.		10. IF UNDER 1 YEAR Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundress		10b. KIND OF BUSINESS OR INDUSTRY — —	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME James Spencer		14. MOTHER'S MAIDEN NAME Ellen Ross Moore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. Hospital Records	
17. INFORMANT Crownsville State Hospital		Address Crownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia DUE TO 522x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Old age DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Dehydration, malnutrition, decubitus ulcers			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. —		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) — (State) —	
21. I certify that I attended the deceased from 10/17 , 19 56 , to 11/13 , 19 56 , that I last saw the deceased alive on 11/13 , 19 56 , and that death occurred at 4:45 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Lionel McHenry Mapp M.D. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 11/14/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-17-56	
22c. NAME OF CEMETERY OR CREMATORIAL Graves Monroe Cemetery		22d. LOCATION (City, town, or county) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Droy Wilson		ADDRESS 1000 Brattell St. A.V.	
24a. REC'D BY REGISTRAR —		DATE 11-23-56	
24b. REGISTRAR'S SIGNATURE Ruthanne Joyce			

WYOMING STATE DEPARTMENT OF HEALTH - DIVISION OF
HEALTH / CERTIFICATE OF DEATH

DEATH CERTIFICATE

MAY 3, 1956

RECEIVEDWYOMING STATE DEPARTMENT OF HEALTH - DIVISION OF
HEALTH / CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10954

10962 CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Pr. Geo's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deale		c. LENGTH OF STAY IN 1b Transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro		d. STREET ADDRESS Rt. 2., Box 287		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deale Road				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) George		First	Middle William	Last Sturgess	4. DATE OF DEATH November 23	Month 1956.	Day 23	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> March 17, 1877	9. AGE (In years lost birthday) 79 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Samuel Sturgess		14. MOTHER'S MAIDEN NAME Margaret Windsor						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT James E. Sturgess		Address Rt. 2., Box 287, Upper Marlboro, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO <i>Coronary Thrombosis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i>		
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b) DUE TO <i>Atherosclerotic CV Disease</i>				(c)		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. p. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Upper Marlboro	(County)	(State)
21. I certify that I attended the deceased from Dept. , 19 36 , to 23 Nov. , 19 56 , that I last saw the deceased alive on 19 Nov. , 19 56 , and that death occurred at 11:52 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Upper Marlboro, Maryland DATE SIGNED 11/23/56								
ACTUAL SIGNATURE <i>R. B. Sasscer</i>	M.D.							
PHYSICIAN'S NAME (Type) R. B. Sasscer, M. D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/27/56	22c. NAME OF CEMETERY OR CREMATORIUM Trinity Cemetery		22d. LOCATION (City, town, or county) Upper Marlboro, Maryland		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros.		ADDRESS Upper Marlboro, Maryland		24a. REC'D BY REGISTRAR Nov 30-1956-9. B. Dent	24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

INSTRUCTIONS

within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

certified death certificate

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10963

CERTIFICATE OF DEATH

Reg. Dist. No......

10955

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY OR TOWN		MARYLAND LENGTH OF STAY (in this place)		STATE CITY OR TOWN		COUNTY CITY OR TOWN <i>(If outside corporate limits, write RURAL and give nearest town)</i>	
<i>Arnold</i>				<i>Md.</i> <i>Arnold</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS <i>(If rural give location)</i>			
3. NAME OF DECEASED (Type or Print)		(First) <i>Edith</i> (Middle) <i>Elizabeth</i> (Last) <i>Thieme</i>		4. DATE OF DEATH		(Month) <i>11</i> (Day) <i>- 12 -</i> (Year) <i>1956</i>	
S. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	MARRIED	<i>2-23-1894</i>	62 yrs.	Months	Days	Hours Min.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
<i>Housewife</i>		<i>Home</i>		<i>Prince George Co Md</i>		<i>U.S.A.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		<i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		18. MEDICAL CERTIFICATION	
(If Yes, give war or dates of service)				<i>Alvin Thieme</i>		<i>2</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
334x IMMEDIATE CAUSE (A) <i>Angina due to Paralysis of the</i>							
ANTECEDENT CAUSE(S) DUE TO (B) <i>Throat</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Hypertension - Aprosopogia.</i>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
M.							
22. I hereby certify that I attended the deceased from <i>April 19</i> , 1954, to <i>Nov. 16</i> , 1956, that I last saw the deceased alive on <i>Nov. 16</i> , 1956, and that death occurred at <i>6:30 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>T. G. de Ossedo</i> M.D. ADDRESS (Street, city, town, state) <i>Arnold - Md.</i> DATE SIGNED <i>Nov. 19, 1956</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>11-19-56</i>		NAME OF CEMETERY OR CREMATORIAL <i>Asbury Cemetery Arnold</i>		LOCATION (City, town, or county) <i>Md.</i> (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>G. Wm. French</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>J. F. J. and Sally French Arnolds</i>		ADDRESS <i>Md.</i>	
DATE <i>11-21-56</i>							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
929 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10956

21

Reg. Dist. No.

10922

O DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

O FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

A15ME(5)
SM 9/55

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE	
<i>Anne Arundel</i> <i>MARYLAND</i>		<i>Maryland</i> <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
<i>Annapolis</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
<i>Larkin St</i>		<i>60 Larkin St</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		10	
3. NAME OF DECEASED (Type or print)	First <i>George</i>	Middle <i>Thomas</i>	Last <i>11</i>
4. DATE OF DEATH <i>12</i>	Month <i>12</i>	Day <i>1956</i>	Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-11-1866</i>
9. AGE (In years last birthday) <i>90</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. Hours <i>0</i>
13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Handyman</i>	14. KIND OF BUSINESS OR INDUSTRY <i>Putland, Md</i>	15. BIRTHPLACE (State or foreign country) <i>U.S.A</i>	16. CITIZEN OF WHAT COUNTRY?
17. FATHER'S NAME <i>John Henry Thomas</i>	18. MOTHER'S MAIDEN NAME <i>Elizabeth Thomas</i>	19. ADDRESS <i>Mary Thomas - 60 Larkin St</i>	20. INTERVAL BETWEEN ONSET AND DEATH
21. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <i>No</i>	22. SOCIAL SECURITY NO.	23. INFORMANT	24. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
25. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450.0</i> DUE TO <i>Underlying disease Generalized</i>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
26a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		26b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
26c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	26d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	26e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
26f. (City or town) <i>Annapolis</i>	(County) <i>Anne Arundel</i>	(State) <i>Maryland</i>	
27. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Portland</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>11/12/56</i>
EXAMINER'S NAME (Type) <i>E. Linhardt</i>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
28. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	29b. DATE THEREOF <i>11-15-56</i>	29c. NAME OF CEMETERY OR CREMATORIAL <i>Brewer Hill</i>	29d. LOCATION (City, town, or county) <i>Annapolis, Md</i>
29e. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, Jr.</i>		29f. ADDRESS <i>Annapolis, Md</i>	29g. REGISTRAR BY REGISTRAR <i>Nov. 15, 1956</i>
29h. REGISTRAR'S SIGNATURE <i>J. French</i>			

MISSOURI STATE POLICE - DIVISION OF
EXAMINER'S CERTIFICATE OF DEATH

BUREAU Y.

CV 15 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH												Reg. Dist. No. 10957
10964 Items 8,9: fd 11-27-56 L												
1. PLACE OF DEATH a. COUNTY Anne Arundel			MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum			c. LENGTH OF STAY IN lb 14 years			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Same b. COUNTY Same			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hammonds Ferry Road Box 272						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same						
3. NAME OF -DECEASED- (Type or print) Richard Celestine Towson (Towson)			First	Middle	Last	4. DATE OF DEATH November 22			Month	Day	Year	
5. SEX M	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 6/19/56 1881	9. AGE (In years last birthday) 75 80 yrs.	IF UNDER 1YEAR Months 7 Days 0			IF UNDER 24 HRS. Hours 0 Min. 0					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired carpenter			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Baltimore Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Towson			14. MOTHER'S MAIDEN NAME Estelle ?									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 214-05-2988			17. INFORMANT Mrs Estelle Towson (wife)			Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary Occlusion												INTERVAL BETWEEN ONSET AND DEATH Sudden
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>												
ACTUAL SIGNATURE <i>Gustave H. Faubert M.D.</i>												DATE SIGNED 11/23/56
EXAMINER'S NAME (Type) Gustave H. Faubert M.D.			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF Nov. 26-56			22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery			22d. LOCATION (City, town, or county) Baltimore City Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE, <i>Richard J. Langford</i>			ADDRESS <i>Glen Burnie</i>			24a. REC'D BY REGISTRAR DATE <i>146 Nov 27 1956</i>			24b. REGISTRAR'S SIGNATURE <i>L.J. Redick</i>			

THE STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

OBITUARY

SEARCHED

INDEXED

FILED

BUREAU N.Y.

NOV 27 1956

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10958

10923 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY STREET ADDRESS		
ANNAPOULS AA GENERAL	MARYLAND AA	MARYLAND Annapolis on the Bay	MD AA		
3. NAME OF DECEASED (First) (Middle) (Last)			4. DATE OF DEATH (Month) (Day) (Year)		
WALTER L. TYLER			11 - 24 - 56		
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, Specify widower	8. DATE OF BIRTH Mar. 18-1877	9. AGE last birthday 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Civil Service Carpenter, N. S. Naval Academy	11. BIRTHPLACE (State or foreign country) BALTIMORE Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A
13. FATHER'S NAME Albert L. Tyler		14. MOTHER'S MAIDEN NAME Katherine Mason			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No ✓ Spanish American War		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs Clifford Jones Annapolis Md.	
18. MEDICAL CERTIFICATION <i>Azotemia</i> <i>Chronic nephritis</i> <i>Atherosclerotic heart Disease</i> <i>Coronary Thrombosis</i>					
INTERVAL BETWEEN ONSET AND DEATH 2 wks. 4 wks. 6 wks. 6 wks.					
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 4200, IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			(A) (B) (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Oct. 1, 1956, to Nov. 24, 1956, that I last saw the deceased alive on Nov. 24, 1956, and that death occurred at 10 AM, from the causes and on the date stated above. SIGNATURE <i>James D. Martin</i>					
23. BURIAL, CREMATION, REMOVAL (SPECIES) Funeral		DATE THEREOF 11-27-56	NAME OF CEMETERY OR CREMATORIUM HILLCREST	ADDRESS (Street, city, town, state) 185 Prince George St. Annapolis MD LOCATION (City, town, or county) ANNAPOLIS MD State	
24. REC'D BY REGISTRAR DATE		REGISTRAR'S SIGNATURE John W. Taylor		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John W. Taylor Annapolis Md.	

STATE DEPARTMENT OF PUBLIC WELFARE

REGISTRATION OF DEATH

DEATH CERTIFICATE NUMBER

NAME OF DECEASED

CHICKEN

ADDRESS

AGE

SEX

CAUSE OF DEATH

TIME OF DEATH

PLACE OF DEATH

NAME OF DOCTOR

NAME OF HOSPITAL

NAME OF FUNERAL DIRECTOR

NAME OF CEMETERY

NAME OF FUNERAL HOME

NAME OF ATTORNEY

NAME OF POLICE OFFICER

NAME OF FIRE DEPARTMENT

NAME OF MEDICAL EXAMINER

NAME OF CORoner

NAME OF JUDGE

NAME OF ATTORNEY GENERAL

NAME OF ATTORNEY FOR DEFENDANT

NAME OF ATTORNEY FOR PLAINTIFF

NAME OF ATTORNEY FOR DEFENDANT IN CIVIL CASE

NAME OF ATTORNEY FOR PLAINTIFF IN CIVIL CASE

NAME OF ATTORNEY FOR DEFENDANT IN CRIMINAL CASE

NAME OF ATTORNEY FOR PLAINTIFF IN CRIMINAL CASE

NAME OF ATTORNEY FOR DEFENDANT IN MURDER CASE

NAME OF ATTORNEY FOR PLAINTIFF IN MURDER CASE

BUREAU V. S.

DOV 28 1956

REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10959

10924 CERTIFICATE OF DEATH

Reg. Dist. No 21

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Anne Arundel</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riva</i>		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>River Anne Arundel General Hospital</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>William</i>	Middle <i>E</i>	Last <i>Van Wart</i>	4. DATE OF DEATH	Month <i>November</i>	Day <i>9</i>	Year <i>1956</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 12, 1882</i>	9. AGE (In years last birthday) <i>74 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired - Supt.</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Apt. House</i>	11. BIRTHPLACE (State or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
13. FATHER'S NAME <i>Unknown</i>	14. MOTHER'S MAIDEN NAME <i>Unknown</i>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>101-03-0071</i>	17. INFORMANT <i>Mrs. Alice Stanton- Daughter- same as # 2</i>	Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary artery occlusion</i> DUE TO (c) <i>Coronary atherosclerosis.</i>									
INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Hour a. m. p. m.	Month <i>19</i>	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>11/18/56</i>	(County) <i>11/19/56</i>	(State) <i>11/19/56</i>	
21. I certify that I attended the deceased from <i>11/8</i> , 19 <i>56</i> , to <i>11/9</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>11/9</i> , 19 <i>56</i> , and that death occurred at <i>5:05 A.M.</i> from the causes and on the date stated above.									
ADDRESS (Street, city or town, state)									
ACTUAL SIGNATURE <i>John H. Hedeman</i> M.D. <i>90 Cathedral St. Annapolis, Md.</i> DATE SIGNED <i>11/2/56</i>									
PHYSICIAN'S NAME (Type) <i>John Hedeman</i>		MD		22c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Olivet Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Maspeth, Long Island, New York</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal-Burial</i>		22b. DATE THEREOF <i>11-13-56</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Olivet Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Maspeth, Long Island, New York</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hopping Funeral Home</i>		ADDRESS <i>172 West St. Annapolis, Md.</i>		24a. REC'D BY REGISTRAR- <i>Nov 13 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Wm. J. French</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10955 CERTIFICATE OF DEATH

10960
28

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD		b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CROWNSVILLE, ANNAPOLIS		c. LENGTH OF STAY IN 1b 9 yrs 5m 0s		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		d. STREET ADDRESS 311 N STRICKER ST			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CROONSVILLE STATE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) MARY Antoinette WADE		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
5. SEX F	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 8, 1885	9. AGE (in years last birthday) 71 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME UNK HENRY F. WADE		14. MOTHER'S MAIDEN NAME ANNA Legrean				Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) AURICULAR FIBRILLATION DUE TO (c) Arterosclerotic CARDIOVASCULAR DISEASE			
						INTERVAL BETWEEN ONSET AND DEATH approx 48 hrs			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Crownsville Md.	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov 15 , 1956, to Nov 17 , 1956, that I last saw the deceased alive on Nov 17 , 1956, and that death occurred at 7:45 PM, from the causes and on the date stated above. ACTUAL SIGNATURE George E. Mck Phillips M.D. ADDRESS (Street, city or town, state) Crownsville Md. 11-18-56		DATE SIGNED							
PHYSICIAN'S NAME (Type) GEORGE E. MCK PHILLIPS		22c. NAME OF CEMETERY OR CREMATORIUM arbitus		22d. LOCATION (City, town, or county) md		(State)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-20-56		22c. NAME OF CEMETERY OR CREMATORIUM arbitus		22d. LOCATION (City, town, or county) md			
23. FUNERAL DIRECTOR'S SIGNATURE George L. Nelson		ADDRESS 1348 N. Calhoun St.		24a. REC'D BY REGISTRAR DATE Nov 19 1956		24b. REGISTRAR'S SIGNATURE H. M. Joyce			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MATERIALS AND STATE DEPARTMENT OF NEVADA - 5011 WINGE 78

1956 CERTIFICATE OF DEATH

100-24000

NOV 20 1956

RECEIVED
FBI - BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10961

CERTIFICATE OF DEATH

Reg. Dist. No.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10965 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12086
28

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>GAMBRILLS</i>		c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	
		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>MARY</i>		First <i>MARY</i>	Middle <i></i>
4. DATE OF DEATH <i>11/12/56</i>		Last <i>WARREN</i>	Month <i>11</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9. AGE (In years from birthday) <i>53 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Skull Fracture</i> <i>812 X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Fracture of neck</i> (c) <i>Compound Comminuted Fracture of both lower legs</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Pedestrian hit by auto</i>			
20c. TIME OF INJURY Month, Day, Year Hour <i>a.m.</i> <i>11/11/56</i> p. m. <i></i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, offi., bldg., etc.) <i>street</i>
20f. (City or town) <i>Anne Arundel Md.</i>		(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>William Updegraff</i>	DATE SIGNED <i>11-12-56</i>		
EXAMINER'S NAME (Type) <i></i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Check) <i>Burial</i>	22b. DATE THEREOF <i>12-21-56</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>C. of Med. Med-School</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>SP</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE <i>DEL 26 1956</i>	24b. REGISTRAR'S SIGNATURE <i>L. M. Leyce</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WEDNESDAY EVENING'S CEREMONY OF DEATH

BUREAU V. S.

DEC 27 1956

REGELIV ECU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10962

10926 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) South River Park				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION A A General Hosp.		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Robert	Middle N.	Lost Williams	4. DATE OF DEATH	Month 11	Day 15	Year 1956
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 31-1904		9. AGE (In years last birthday) 52 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Stoves		11. BIRTHPLACE (State or foreign country) Washington DC		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William Williams		14. MOTHER'S MAIDEN NAME Flora Smith						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> Yes <small>If yes, give rank or date of service</small>		16. SOCIAL SECURITY NO.		17. INFORMANT Marion H. Williams ②		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u>								
DUE TO 443X								
INTERVAL BETWEEN ONSET AND DEATH 2 minutes								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <u>Hypertensive cardiovascular Disease</u>								
DUE TO 2 years								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Doy	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County) Baltimore	(State) Md.
21. I certify that I attended the deceased from <u>11/2</u> , 19 <u>56</u> , to <u>11/15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/15</u> , 19 <u>56</u> , and that death occurred at <u>Baltimore</u> M, from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) 90 Cathedral St- Annapolis, Md.								
DATE SIGNED 11/16/56								
ACTUAL SIGNATURE <u>John L. (Kleeman)</u>		M.D.						
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-17-56		22c. NAME OF CEMETERY OR CREMATORIUM Washington National		22d. LOCATION (City, town, or county) Baltimore		
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons Annapolis Md</u>		ADDRESS Annapolis Md		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE <u>O. O. Smith</u>		

WISCONSIN STATE GOVERNMENT OF HONORABLE SAVINGS

CERTIFICATE OF DEATH

RECEIVED		RECEIVED	
BUREAU Y.		NOV 19 1956	
NOV 19 1956			
RECEIVED			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

10963 78

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18
Item 11 FilmG207 11-21-56 et

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY Anarundel		MARYLAND	STATE Maryland		Arundel
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Herald Harbor		STREET ADDRESS (If rural give location)
TOWN Millersville					
HOSPITAL OR INSTITUTION OR STREET ADDRESS Banns Nursing Home.					
3. NAME OF DECEASED (Type or Print)			4. DATE (Month) (Day) (Year)		
(First) Frederick (Middle) W. Willner (Last)			November 12th, 1956		
S. SEX Male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, Married	8. DATE OF BIRTH May 8, 1874	9. AGE last birthday 82	IF UNDER 1 YEAR Months 0 Dey 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
			Washington, D.C.		
13. FATHER'S NAME Francis H Willner			14. MOTHER'S MAIDEN NAME Frances Mulligan		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY NO.		
			17. INFORMANT & ADDRESS Warren H Willner-Herald Harbor, Md.		
18. MEDICAL CERTIFICATION					
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 450.0 IMMEDIATE CAUSE (A) <i>Generalized Arteriosclerosis</i>					
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO 904.9 (C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Fractured LEFT Femur 4 MO					
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21c. WHERE DID INJURY OCCUR? (City or town) Baltimore, Md. (County) Md. (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.			21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		
21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from Sept. 19, 56, to Nov. 12, 1956, that I last saw the deceased alive on Nov. 12, 1956, and that death occurred at 8:45 A.M. from the causes and on the date stated above.					
SIGNATURE Edward J. Henretta ADDRESS (Street, city, town, state) Baltimore, Md. DATE SIGNED 11-12-56					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			DATE THEREOF 11-14-56 NAME OF CEMETERY OR CREMATORIAL Cedar Hill LOCATION (City, town, or county) Suitland, Md. (State)		
24. REC'D BY REGISTRAR 11-14-1956			REGISTRAR'S SIGNATURE J. M. Joyce ADDRESS J. O. L. L. Sons Co. Wash. D.C.		
25. FUNERAL DIRECTOR'S SIGNATURE J. O. L. L. Sons Co. Wash. D.C.					

BUREAU V. S.

1956 11 10

REFEVIEWED